

ANUARY 1949

In This Issue: **CUT FEES
MEAN CUT THROATS**

Greater Philadelphia Dental Society, Annual Meeting, Feb. 2-4

Oral HYGIENE





Sani-Terry HANDPIECES

**ADD to your patient's comfort
SUBTRACT from your own fatigue**


Nine times out of ten a patient will tell you what he dreads most is the operation of the handpiece, though he may call it "drilling" or "grinding."

When a SANI-TERRY Handpiece is used there is much less discomfort for the patient and less fatigue for the dentist. A new SANI-TERRY Handpiece is true-running, smooth in operation and free from unnecessary vibration. It retains these qualities because of its unusual resistance to wear. Work proceeds more rapidly because of the patient's freedom from strain.

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CLEV-DENT CONTRA-ANGLE U

If preferred, Clev-Dent Contra-Angle U may be used with the Sani-Terry Handpiece. It fits accurately over the handpiece and is free from unnecessary vibration.



Confidence with KONFORMAX!



When you look at a Konformax Full Mouth Impression, you can believe what you see. You can feel confident the resulting denture will fit accurately.

- ➔ Use with any technique.
- ➔ Flows without pressure.
- ➔ No dimensional change.
- ➔ Does not dehydrate tissue.
- ➔ Does not distort.
- ➔ Pour model any time.
- ➔ Easy to use.

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TAKES THE IMPRESSION

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CITY.....STATE.....

"MY dent



Priscilla

COOK-WAITE
Laboratories, Inc.
New York, N. Y.

Doesn't hurt!"

HIGH praise, indeed! He may not know an M.O.D. from an impacted upper molar, but he does know if it hurts. And if it does, he's very apt to see another dentist — or none at all! You may have done the finest job that any dentist could . . . but it won't do you any good if he's afraid to return!

Novocain - Pontocaine - Cobefrin's deep, dense, lasting anesthesia — achieved without perceptibly decreased patient-tolerance — is well calculated to give an affirmative answer to that all-important "will he come back?" question. He will indeed — if you've relied on "N.P.C."!

Try "N.P.C." today...and listen to your patients say "MY dentist doesn't hurt!"

npc

"the Difference is Distinctive"

The Publisher's CORNER

By Mass

Number 33



ABOUT ANNIES

HERE COMES a letter (as this is written in November) from Doctor R. J. Carabin of San Antonio, Texas, commenting on the November CORNER about dental assistants. Maybe you remember that this one presented the views of Miss Betty Frederick of Canton, Ohio; she's secretary of the Ohio State Dental Assistants' Association, and champions certification of assistants.

Betty had reached for her typewriter when she read the September CORNER which had quoted and unquoted a dental patient, Miss E. A. Luster of Louisville, Kentucky. Miss Luster had complained, among other things, about her dentist's assistant "a listless assistant who read *True Stories* while on duty," and otherwise didn't assist very much.

Doctor Carabin writes, "It did me a lot of good to read what Miss Betty Frederick had to say. But she is young yet and has missed some things. For instance, she might ask some of the older dentists up there in Ohio if they can remember when it was customary to *wash the forceps in cold water* at the old Sta

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University. They will tell her 'yes,' and add that they never observed any bad effects. Later, in the new school, the instruments were boiled, but a nice colored lady rolled plenty of cotton pellets for the boys to use in sockets. At the time, I thought this broke the asepsis chain—but then I was young, too—like Betty. We must all uphold the dignity of our profession."

Doctor Carabin continues: "For thirteen years, I was on the staff of a state hospital. Trained nurses were a dime a dozen. Some of them were unusually capable, but most of them were not as good as a ward attendant who helped in the dental office. Somehow, certificates don't certify intelligence."

Thinking of dental assistants started Doctor Carabin to reminiscing about his own. "When I moved downtown, I hired a very nice assistant. She had a long last name, but her first name was very handy: it is Annie." The doctor wasn't sure he ought to call her that. "When the dignified dental equipment salesman presented me with my bill, I asked his advice, 'Do you think it would be all right for me to call this girl Annie?'"

"'Oh my, no!,' he exclaimed. 'The girls in *our* office, after being there for years are still called Miss This and Miss That.'"

"The same morning," Doctor Carabin remembers, "I had occasion to visit a neighboring dentist who pays the Government more than I earn. I'll see how *he* does it, I thought.

"Just then, he decided to extract some teeth. 'Give me some novocain, girly!' he called out."

That must have been enough for Doctor Carabin. "I confess that for six years I've addressed my assistant as Annie. The other day, she ups and gets married. But she has come back to help out for a while. Of course, she has a new last name. Perhaps she told me what it is, but darned if I can remember. Anyway, she comes if you call 'Annie!'" Maybe it will be fun if the CORNER controversy about dental assistants starts off on this new tack.

When asked if it was jake with him to quote him, the doctor

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Let Kolynos help teach your patients the importance of oral hygiene. Regular brushings with Kolynos, help remove ordinary surface stains, brighten teeth made dull through improper cleansing. It's a *pleasure* to use Kolynos too. The cool, minty flavor leaves the mouth feeling refreshed long after the teeth are brushed. Next time one of your patients asks, "What dentifrice should I use, doctor?" why not suggest, "Kolynos".



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said "Sure!" At the foot of his letter, Annie said it was all right with her, too, and confided that her old last name was (or so it looks to these ageing eyes) Cullinane and the new one Hilbig.

This office has an Annie, too; she's my assistant but right now she's vacationing in Mexico and all I hope is that she gets back here quick—before I completely unravel. Annie's last name is Andraso. Long ago, I decided I couldn't be hollering "Miss Andraso!" all the time. I think Doctor Carabin is right.

ORAL HYGIENE'S Annie is "Annie" to lots of people in the dental field, too. In fact, she's "Little Annie" to most of them, to many who have never met her. They're fond of her because she is never too tired or too busy, somehow, to do things for them when they write in; and she just naturally puts a humorous twist in most of her letters, sometimes decorates them with little cartoons.

If somebody starts certifying publishers' assistants, Little Annie will sure enough get a diploma. She'll probably draw some cartoons on that, too.

Another dental assistant wrote in, Mrs. Pearl Davison who assists the famous Sage of Red Bank, New Jersey—Doctor Herbert Ely Williams. She and the doctor both agree that a dentist who disparages another isn't fit to be a member of the profession. She'd heard of one disparaging remark that backfired, and how. It chanced that the restoration which was sneered at had been the work of the patient's own brother. Oh, oh!

Pearl says, "I didn't know that so many folks had never heard of the Golden Rule."

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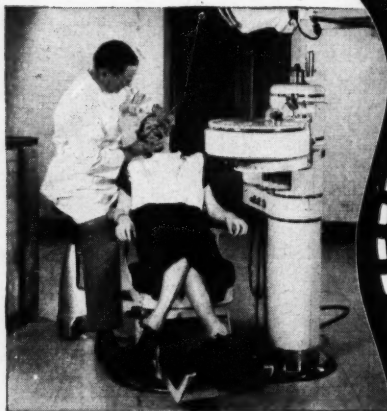
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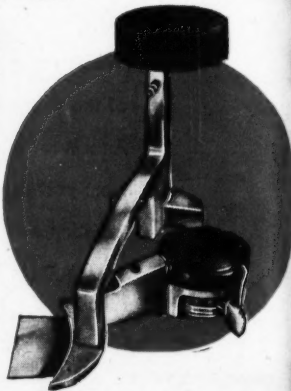
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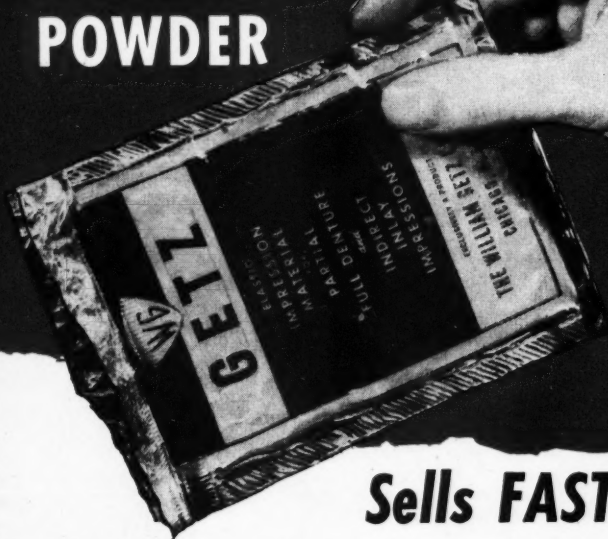
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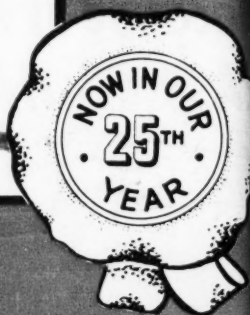
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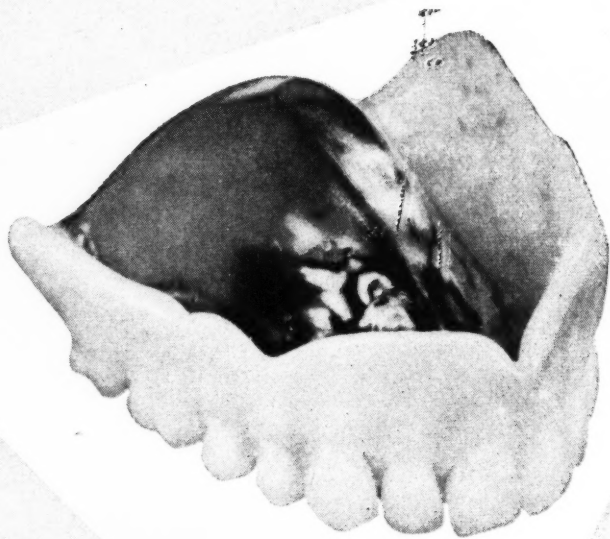
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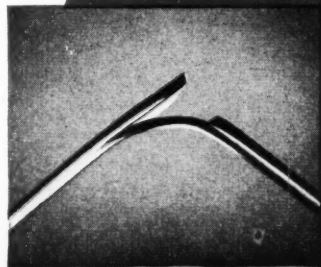
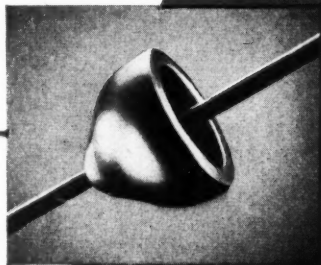
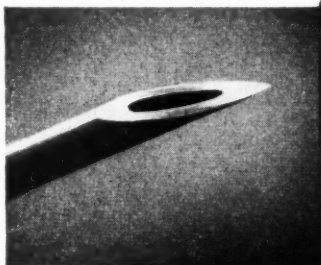
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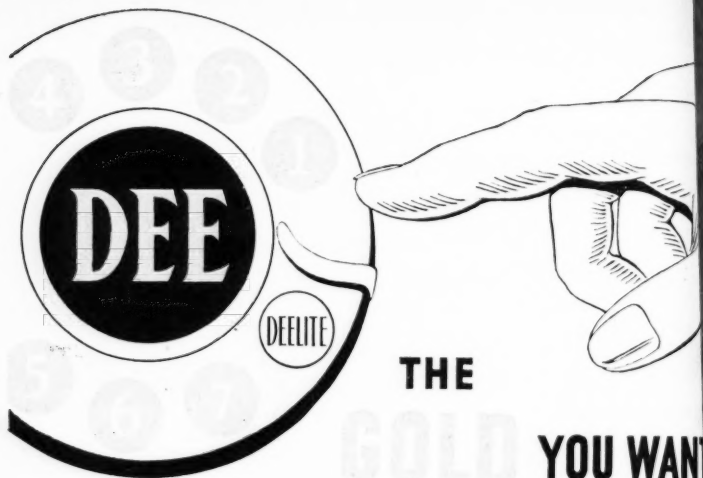
Because corrosion-resistance has been maintained at the highest stainless steel levels, these new Carpule Needles remain bright and clean both inside and out.

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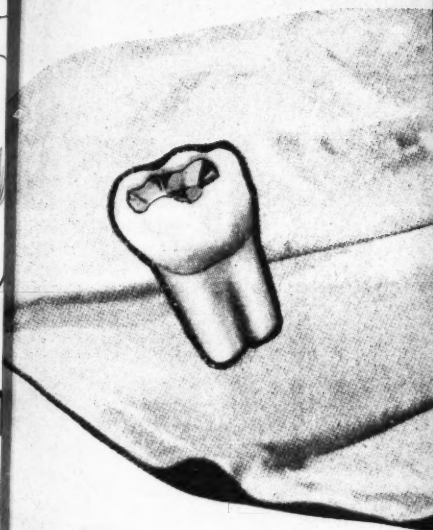
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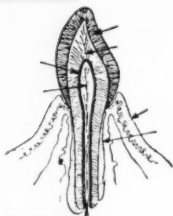
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Citrus fruits help build teeth



C deficiency may cause tissue degeneration in enamel, cement, dentine, odontoblasts, pulp, and gingiva.

The role of nutrition—particularly of vitamin C in tooth health and development is receiving increasing emphasis.³ Dietary deficiencies of ascorbic acid are the reported etiology in many cases of dental osteoporosis, pulp necrosis, pyorrhea alveolaris and gingivitis.² And in the growing tooth, interference with dentine, enamel and cement formation have been demonstrated,¹ with marked alterations of odontoblasts and liquefaction of dentine³ under C deficiency.

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REFERENCES:

1. Boyle, P.E. et al: Proc. Soc. Exp. Biol. & Med., 36:773, 1937.
2. Bridges, M.A.: Dietetics For The Clinician, Lea & Febiger, Phila., 4th ed., 1938.
3. Rose, M.S.: Rose's Foundation of Nutrition, revised by G. MacLeod and C. Taylor, Macmillan Co., New York, 4th ed., 1944.
4. Sherman, H.C.: Chemistry of Food and Nutrition, Macmillan Co., New York, 7th ed., 1946.

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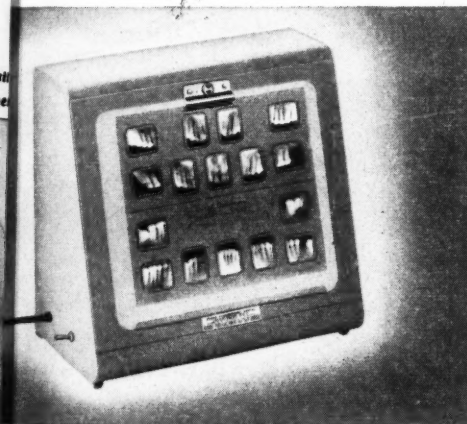
General details—Positive-type switch located on left side. Electric cord of generous length. Four rubber feet . . . one at each corner.

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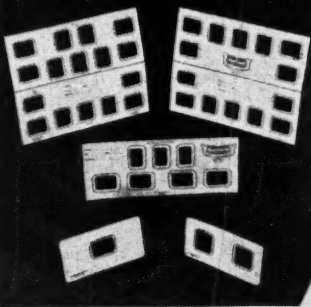
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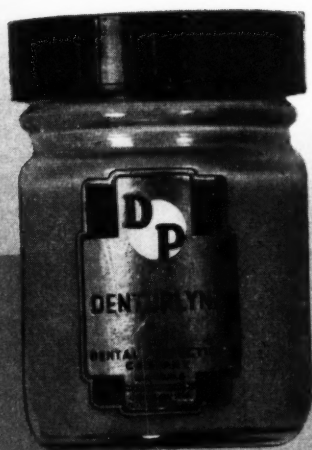


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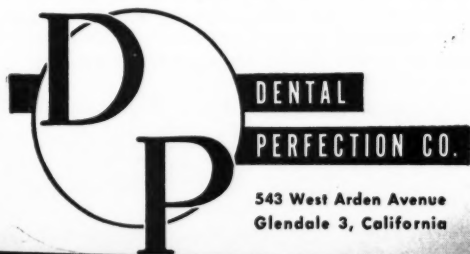
New Stabilized Formula

INSURES PERFECT BALANCE

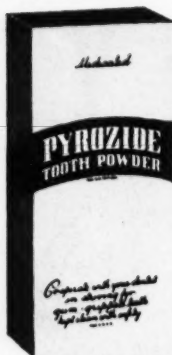
DENTURLYNE'S new stabilized formula offers you these important advantages in your practice:

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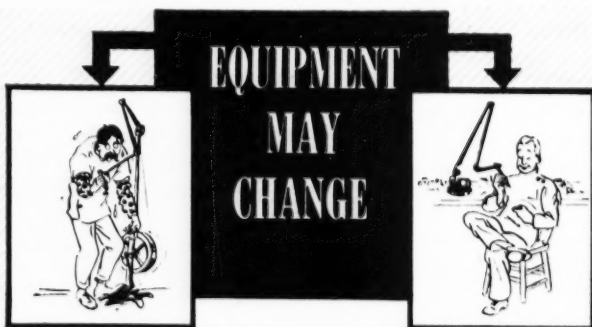


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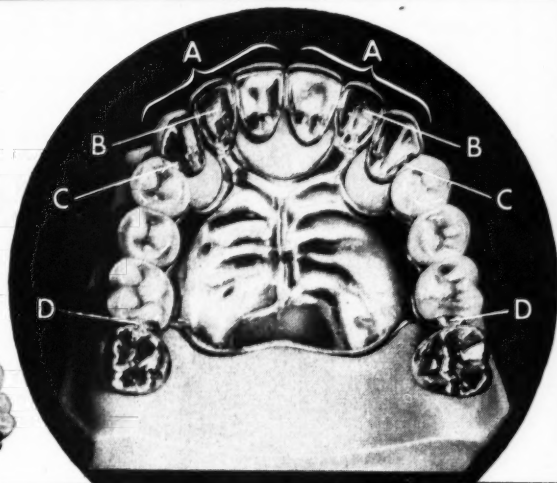
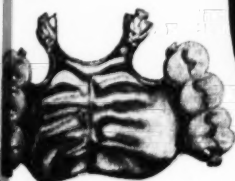


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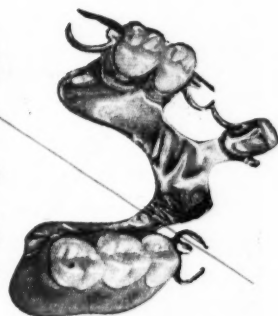
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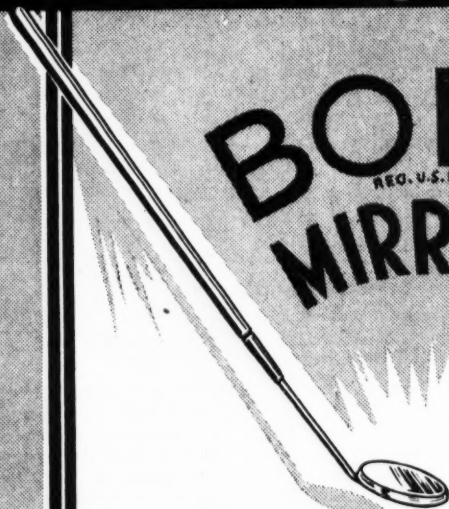
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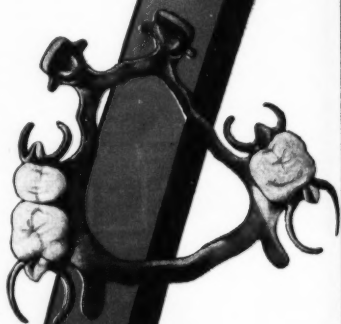
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EDITOR

Edward J. Ryan

B.S., D.D.S.

ASSOCIATE EDITOR

Marcella Hurley

B.A.

ASSISTANT EDITOR

Florence E. Biller

B.A.

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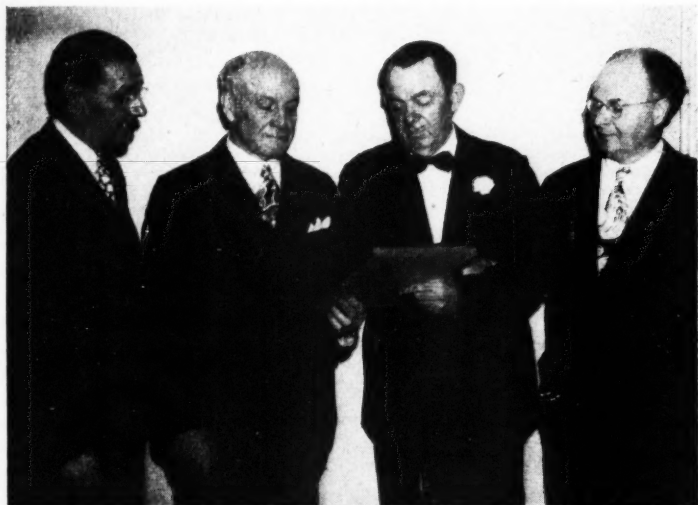
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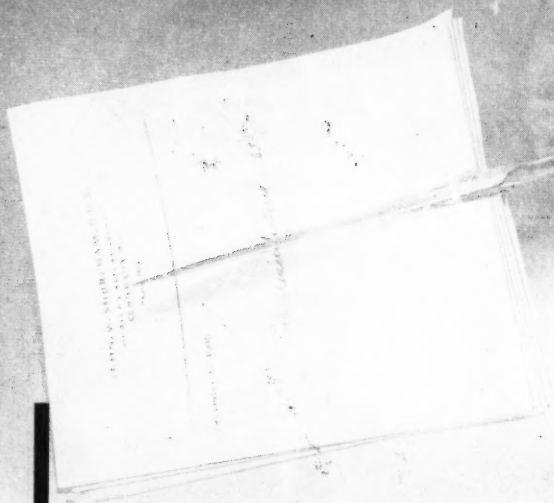
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Picture of the Month



AT THE 1948 annual meeting of the American Association of Orthodontists, Clinton C. Howard, of Oakley, South Carolina, receives the Albert H. Ketcham Award. From left to right are: Allan G. Brodie, Chicago, Illinois; O. W. White, Detroit, Michigan; Doctor Howard; and B. Holly Broadbent, Cleveland, Ohio. Doctor Broadbent received the Award in 1944.—*Photograph by Howard A. Hartman, D.D.S.*

Ten dollars will be paid for the picture used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 Church Street, Evanston, Illinois.



Cut Fees Mean Cut Throats

By **HARRY C. PEAKE, D.D.S.**

THE FEE-CUTTING problem is one which must be faced by the younger generation of dentists, even at the risk of offending some of the older men of the profession. However, this is a matter which might better be presented by one of the

older men. After being in practice for twenty-three years, I feel I may air this grievance for the recent graduate without fear of being accused of "griping."

Fee-cutters fall into two distinct classes. The first class, that of contemporary dentists who cut fees—and hence their confreres' throats—can be handled only by legislation. That may seem like a drastic statement, but until such time as official action is taken, the fee-cutter—like the tax collector—will be with us.

The other class of fee-cutters includes some of the older members of the profession. Their fee cutting is mostly thoughtlessness. In most cases, if it were brought to their attention, and they were accused of placing the younger men in a com-

*Dentist suggests that action be taken to prevent
dental fee cutting.*

promising position, they would be amazed and hurt.

But the fact remains: whether knowingly or not, many elderly dentists are guilty of fee cutting. However, if this situation were explained to them, and the position of the recent graduate pointed out, most would be willing to assist in clearing up the injustice.

"Retired Dentists"

Take the case of Doctor Jones, for instance. This dentist is getting along in years and has decided to retire. But he loves his profession and feels he cannot withdraw from it completely. He still has his equipment, and perhaps his office is in his house. What could be more natural than that he should "putter around," doing an extraction here and a restoration there?

Then comes the question of fees. Doctor Jones is not practicing now because he must earn his living. He has money in the bank, so he quotes a fee which would have been a nominal charge in his younger days, when butter could be purchased for 15 cents a pound, and a good steak cost a quarter.

Then there is the case of Doctor Smith. He has had a busy practice in the city, but has decided to move to a small town and take things easy while on the downward path of life. With a steady income from his investments, and a comfortable

home, he does not need to worry about the future.

Reduced Fee

One day a new denture patient comes to Doctor Smith's office. The dentist looks the patient over and decides he has not too much of this world's goods. The other men in his district are charging \$50 for a similar case, but Doctor Smith can afford to be big hearted. "W-e-e-e-e-l," he says, looking over his glasses, "this isn't my regular fee, but I'll complete your case for \$40."

The patient is impressed, but every dentist practicing in the vicinity has had his throat cut. When Doctor Smith fashioned those dentures, he also fabricated a small snowball which immediately started rolling down hill—getting larger as it rolled.

As the patient left the office, he met a friend. "Hiyah, Joe!" said the friend. "Got some new snappers, I see. What did they set you back?"

"I got them from Doctor Smith," the patient told him. "I'd been around to all the other dentists in town. They all wanted \$50, but Doc Smith only charged \$40. Maybe he gave me a bit of a cut," he added.

Pretty soon the friend meets another friend. "Joe Jerk got some new china clippers," he recounts.

"He got 'em from Doc Smith, and they only cost him four sawbucks."

That is not putting it in professional language, but it is the way our patients talk among themselves. Pretty soon the story is all about town, and overnight Doctor Smith is the only ethical dentist, while the others are a lot of robbers who compare with Dick Turpin and Captain Kidd.

Is this fair to the other dentists who are trying to conduct practices in an honest and ethical manner? It most certainly is not, and the act which was meant as one of kindness on the part of Doctor Smith has become a boomerang. Instead of just putting along to keep his hand in while he grows old, he has become the best-known dentist in town, and his confreres are considered to be a lot of grasping, profiteering "shysters." The fact that Doctor Smith is an old man, and is using out-dated methods of denture construction, does not enter the minds of the patients. That *he* can make a denture for \$40, while the others charge \$50, is the point they remember.

One can sympathize with an older man wanting to keep his hand in at the profession of his choice—provided he maintains his fees at the level of those of other dentists in his vicinity. If he does not, such practice is absolutely unfair to recent graduates. These younger men have as great a love for their profession as the ones who have spent their lives in it, but added to that, they have the necessity of earning

their living. Where the fee means nothing to the man who has—as he says—"retired," to the man just out of college it means the difference between progress and going in the red.

I have vivid recollections of a gentleman old enough to be my grandfather. He refused to give up although he might have retired, as far as financial reasons were concerned, years before he finally did take that step. He would come to the building in which I was practicing, dressed in a frock coat, and borrow my office to treat patients (still in the frock coat) who might normally have been coming to me. Had I pointed out to him that he was taking the bread and butter out of my mouth, he would have been deeply hurt.

Minimum Fee Scale

Dentistry is supposed to be a progressive profession, but there is a sad need for legislation which would make all forms of fee cutting illegal. If a patient gets an ache or breaks out in a rash, he goes to a physician, takes his treatment, and pays his fee without question. However, the same patient, when he needs dentures, will go to every dental office within reach and inquire about the fee. In some localities, he will get a different answer in every office.

If there were a rigid minimum fee scale set—and enforced—the young graduate would not feel the need to bargain when a patient whom he needs badly comes to his

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January, 1949

ORAL HYGIENE

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ORAL HYGIENE AWARD

This article by HARRY C. PEAKE, D.D.S., has won the \$100 ORAL HYGIENE award for the best feature published this month.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

office for "consultation." If he knew there were no throat-cutters at large he could stand on his two feet, throw out his chest, and say: "My fee is \$100, Mr. Patient. I'll give my full attention to your case, and I'm sure I can satisfy you, but there can be no reduction in my charges."

He would know this patient could not go to the next office and say: "I've had a quotation of \$100. What's your best bid?" He would also know that he did not need to skimp on buying of supplies—and hence perform inferior treatment—to meet the figure he had been forced to quote.

Could this patient go into different barber shops and get differing charges for a hair cut? Then why should dentistry, which we term a profession, lag behind what we are pleased to call a trade? But the barbers *are* organized, while the dentists *say* they are. Dental organizations should take a leaf from the books of the trade unions. A little more practice for the good of the profession, and less mutual admiration, would be a good sign.

Too many of the men in the dental profession are indifferent to the struggles of the younger generation, and the elimination of fee cutting is a good place to start to show a newborn interest. The recent graduate of today will be the backbone of the profession tomorrow. He will be; that is, provided he is not smothered out of existence by unthinking or unscrupulous opposition.

*Timberlea
Parkhill, Ontario, Canada*

CORRECTION

WE REGRET that on page 1582 of the October, 1948, issue of ORAL HYGIENE a statement was made that The Physicians Forum, Inc., was an organization in the United States that had been declared subversive by the Department of Justice. We are informed by The Physicians Forum that this organization is not and never has been declared subversive by the Department of Justice and are glad of the opportunity to make the correction.



CHILDREN

Are Easy

to Handle

By EDWARD S. MACK, D.D.S.

*These suggestions may help
you in handling your young
patients.*

CONTRARY TO the assumption of many dental operators, most children may be controlled easily in a dental chair for any normal dental procedure. The common difficulties experienced by dentists often are brought about by their own responses to the reactions of children.

Let us begin by the realization that crying out in response to pain or fear is a normal reaction and not to be considered a behavior problem.

The child rarely enters the dental office without fear. He learns his fear in diverse ways. He learns from overhearing conversations at home and from exaggerations of his playmates. He has a healthy, natural fear of new surroundings; especially ones which he does not

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understand. He compares the dentist's white uniform to that of his physician. He often becomes suspicious of the presence of a nurse. It is quite disturbing for him to discover that his mother is to go only as far as the reception room, and that he must go on alone with this unknown "giant."

Fear of a dentist and his office is natural and should be expected. It is a rare child who is impassive and devoid of apparent emotion; and this does not usually show a healthy reaction pattern.

There are, according to McBride,¹ five major artificial classifications of children:

1. Timid, frightened children
2. Shy, retiring children
3. Temperamental and hysterical children
4. Incorrigible children
5. Mentally deficient children.

I should like to point out a few of the basic reactions of these children and to present a simple means of successful approach to each.

The *timid, frightened child* does not try to halt the operator. The dentist must be sympathetic and reassuring. If the treatment is done painlessly, this child becomes a good patient.

The *shy, retiring child* has "bottled" emotions, and, in response to a jovial approach, comes out of his shell and becomes friendly. There may be a tendency to operate too long on such a child because the dentist may mistake

bashful negation for apparent lack of susceptibility to being hurt.

The *temperamental and hysterical child* should be premedicated. Surprisingly, he can develop into the best patient and an ultimate practice-builder. This child will usually object to leaving the reception room. It is wise first to have the parent try to bring the child into the operating room. When she fails, it is time for the dentist to be pleasant but firm, and lead the child uncompromisingly away from the parent and into the dental operating room. By such a procedure, the dentist will have obtained full parental approval. This child is filled with imaginary dread which can only be dispelled by efficient, painless dental treatment. Such a child is best treated in the morning when both he and the dentist are fresh and free from fatigue.

The *incorrigible child* may even strike or threaten the dentist. Of course, such a patient should always have been given a sedative. Begin the treatment at once and be stern. If restraint must be used, report it to the parent, lest the child give an exaggerated tale of the dentist's cruelty. While informing the parent of the stern measures taken, remind her never to refer to it to the child in conversation, even by inference. An incorrigible child handled firmly and without display of emotion by the dentist soon ceases to be incorrigible.

The *mentally deficient child* who is "slow" to respond is given extra

¹McBride, W. C.: *Juvenile Dentistry*. Philadelphia, Lea & Febiger, 1947, page 25-33.

time to react to the dentist's suggestion or request. These children will stare at one with a blank expression and often with apparent open defiance, yet slowly and definitely respond to orders.

When treating a child, almost always use sedation until the patient has had an opportunity to establish confidence. This often takes two or three appointments. An excellent sedative is sodium pentobarbital.² The dosage is given orally according to the weight of the child: 60 pounds— $\frac{3}{4}$ grain; 120 pounds— $1\frac{1}{2}$ grain.

Mentally deficient children may be given a sedative in the form of a suppository. It must be remembered that a child to whom a sedative has been given must never be sent away without a word of caution to the parent. The child should be watched for the remainder of the day.

When operating on a child, keep his head well up and back as the operation proceeds. A child with his chin against his chest does not present an accessible dental field; nor can he be successfully controlled.

A silent sign of welcome in the reception room is a child's piece of furniture or a few children's books. An audible sign of welcome is calling the child by his first name or nickname. Children resent being called "Honey" or "Dearie."²

Try to avoid keeping a child

waiting too long in the reception room. Children react much better when they are quickly ushered into the operating room, quickly treated, and then quickly and pleasantly ushered out.

First Appointment

It is important that a child who has not been initiated to dental procedures have some treatment with dental instruments on the first visit. Even if a simple dental prophylaxis is all that is accomplished, the child will have learned that the dentist is doing something to the inside of his mouth and that it was not unpleasant.³ Woe to the dentist who merely makes an examination and then explains something mysterious to the accompanying parent. He then says in the presence of the child, "Next time we'll begin." Says the child to himself, "Begin what?"

Regardless of your attitude while treating a child, never under any circumstances permit a loss of temper. Never display a lack of emotional balance. Always be firm, but always be controlled.

It should be recognized that the dentist has a splendid opportunity for performing an invaluable service to the child other than dentistry and concomitant with it. He can aid in the child's character-moulding process and a better citizen will be the result.

516 Sutter Street
San Francisco, California

²Sweet, C. A.: Refresher Lectures in Dentistry for Children. June, 1947. College of Physicians and Surgeons, San Francisco, California.

³Hogebom, F. E.: Practical Pedodontia. 1946. St. Louis, C. V. Mosby Company, page 34.

So You Know Something About DENTISTRY! ?

QUIZ LII

1. In children treated topically with a solution of sodium fluoride, caries reduction is approximately (a) 15 per cent, (b) 40 per cent, (c) 75 per cent.
2. Materia Alba is a (a) culture medium for bacteria, (b) drug used as an antiseptic in mouth-washes, (c) white deposit about the necks of teeth and free margins of the gingivae, (d) type of malocclusion.
3. If anadontia refers to congeni-

tal absence of teeth, what does the term adodontia mean?

4. Name five derivatives of barbital which may be used in dentistry.
5. True or false? Hypoplasia of the enamel and malocclusion have been shown to occur more frequently among rachitic than among nonrachitic children.
6. The sudden and painful loosening of teeth in an isolated area usually suggests (a) carcinoma, (b) avitaminosis, (c) malocclusion.
7. Amalgam restorations containing more mercury than the amount recommended by the manufacturers have (a) greater, (b) the same, (c) less, crushing strength.
8. Can hyperparathyroidism be detected in a good dental roentgenogram?
9. What are the Bureau of Standard's requirements for type A, soft gold?
10. Tori palatini are found in females (a) twice as frequently as, (b) as frequently as, (c) less frequently than, in males.

FOR CORRECT ANSWERS SEE PAGE 82



By **LESTER HOLLANDER, M.D.***

DURING ONE of my recent visits in the barber shop I heard a bit of philosophy which I want to pass along. The manager or master barber, a young man of 36, was addressing the entire male ensemble, customers and employees. This was his birthday and he was observing the anniversary of his appearance with a few well-chosen remarks. He assumed that since his family history contained few obituary notices under the age of 70, his own life expectancy was a good one, and even more so since he was as "strong as a bull," "healthy as a nut," he "slept like a log," "ate like a horse," and "worked like a

dog." All in all, here behold a man composed and constructed along durable lines, the envy, if you please, of everyone.

As the recital faded in the silence provoked by the last cliché, I became aware of the rasping, high-pitched voice of the uneven-heeled Negro porter. His tone and address had the unmistakable quality of culpable familiarity.

"Now, Frank," he said, "don't you go getting ready for any long life. It ain't for you. You jess have too much on your mind to go livin' long. You worry too much. When the President goes to some Big Four Meetin', you worry for fear he headin' into a crisis. When John L. furrows his brow, you worry that the power put-out will get below a ten-billion mark. Then there

*Medical Director, Pittsburgh Skin and Cancer Foundation.

*The harmful effects of x-ray radiation are discussed
by a dermatologist.*

are the Dow Joneses on Wall Street. When they go broke, you get the jitters. And lately when the fishing activities don't look good to this fellow Geiger who counts atoms, you keep getting scared. This jess can't go on; no man can tote such a load and live long. No, sir."

I have thought often and long about this episode. Rudyard Kipling expressed this same idea even more simply when he quoted the beggar in India who addressed an English traveler. "Sahib," he said, "you are weighted down too heavily by your baggage."

All this is only too true of professional men and women. We, too, are in a constant state of worry and anxiety about so many ponderables and, in fact, many more imponderables, that we fail to observe actual causes for concern.

What I am leading up to has to do with the circumscribed confines of the stage of our daily activities—the office and its equipment.

In recent years a wonderful machine has been created for us; the x-ray machine. It gives us the opportunity to examine the hidden crevices. It has made of diagnosis a science rather than an art. But with it a new source of danger, a new and heavier weight as an addition to the luggage we must carry about, also has been added.

The energy which the x-ray ma-

chine produces is a form of radiation which is invisible, insensible, and unnoticeable at the time of its penetration, but at the same time it is cell destructive and its action is accumulative.

Radiations

In this atom-splitting world, we are fast becoming acquainted with a few basic facts concerning radiations. Radiations of practical consequence include alpha, beta, gamma, roentgen rays, and neutrons. Radiations are measured almost exclusively by their capacity to ionize air or some other gas imprisoned between electrically charged plates. The rate of discharge of the plates is proportional to the number of ions formed in the air or gas and that in turn to the quantity of impinging radiation. The biologic effects produced by radiation result from this same capacity to ionize the matter, the cells, through which it passes.

There is another physical characteristic of radiation which needs a few explanatory words. This has to do with the length of the radiation waves. Heat and light rays are of the long wave variety, while the radiations from radium, x-ray, and those emanating during an atomic bomb production and especially explosion, are of an infinitesimally shorter variety. The shorter the wave length of the

radiation energy, the greater is its penetrating ability and its ability to cause cellular damage.

Somatic Effects

General periodicals have accentuated the deleterious effects of the atom-generated and explosion-released short wave radiations. Photographs of flesh burns, keloid-like scars on the skin, have been published. The somatic effects of this same radiation have also been indicated. Chiefly we have been told of the deleterious effects upon the gonads, the testes, and the ovaries. It has been stated that these become defunct, or, if not totally so, that the ova and spermatozoa lose some of their vital structure resulting in an alteration of their chromosomes which may so alter their mechanism as to cause, on fertilization, the production of monstrosities in the human, the animal, and the vegetable kingdom.

Somatic damage of workers in an atomic research center in England has already been claimed by the assistant secretary of the Chemical Workers Union. *Lassitude*, cutaneous eruptions, and *impotence* are the symptoms which he enumerated. Although it must be remembered that with the labor government in control in Great Britain workers have every opportunity to exploit real or alleged grievances, it must not be dis-

missed as just another instance of union griping. It may well be true.

To the dentist, who is in daily company of an x-ray machine, this is of more than academic importance, since the radiation produced by his machine has similar somatic effects. This radiation reaches him both directly and also from the scattered radiation which is present in the confines of the room wherein the x-ray energy explodes, *the place where the roentgenograms are taken*. The patient, only infrequently exposed, accumulates but few roentgen rays and thus his total damage is negligible; but the dentist and his assistant belong to an entirely different category. Daily or more often exposed, knowingly or otherwise, they become the recipients and eventually reservoirs of this cell-destroying energy.

The practitioner who *sits down* to take roentgenograms is even in greater danger because of his closer proximity to the source of the energy. *Anemia, sterility, lassitude* may be the reward from such somatic cellular damage.

Protect yourself and your assistant from direct, stray, or scatter radiation by *standing back of a lead wall* while you take roentgenograms with your x-ray machine.

631 Jenkins Building
Pittsburgh, Pennsylvania

Dentists Prove GOOD Credit Risks

Survey shows dentists in ninth place in credit standing.

By ROY DENIAL

AS CREDIT risks, dentists rank ninth in a list of thirty-four occupational groups recently surveyed by the National Association of Personal Finance Companies in cooperation with the Department of Business Administration at the University of Illinois.

This rating indicates that dentists may be in the top half in credit standing among various occupational groups throughout the country.

The complete tabulation by the Association (using 100 per cent as a perfect record) is as follows:

| | |
|----------------------------|------|
| Office Employees | 92.2 |
| Retail Grocers | 89.8 |
| Chain Store Managers | 89.2 |
| Other Retailers | 89.0 |
| School Teachers | 86.4 |
| Railroad Trainmen | 85.8 |
| Railroad Shopmen | 85.2 |
| Retail Salespeople | 83.2 |

| | |
|---------------------------------|------|
| Dentists | 82.2 |
| Physicians | 80.4 |
| Nurses | 71.2 |
| Farmers (Owners) | 70.8 |
| Factory Workers (Men) | 70.0 |
| Traveling Salesmen | 66.8 |
| Filling Station Employees | 63.0 |
| Factory Workers (Women) | 61.0 |
| Lawyers | 60.8 |
| Auto Mechanics | 60.0 |
| Janitors | 60.0 |
| Farmers (Tenants) | 59.2 |
| Brickmasons | 59.0 |
| Firemen and Policemen | 58.2 |
| Railroad Trackmen | 57.8 |
| Coal Miners | 57.6 |
| College Students | 55.6 |
| Domestic Servants | 55.2 |
| Carpenters | 52.6 |
| Hotel Employees | 48.2 |
| Auto Salesmen | 47.0 |
| Common Laborers | 46.0 |
| Restaurant Employees | 44.6 |
| Barbers | 42.8 |
| Truck and Bus Drivers | 42.6 |
| Painters and Decorators | 38.2 |



That Mythical Bird

RECIPROCITY

By ROLLAND B. MOORE, D.D.S.

FROM THE TIME I was graduated in dentistry years ago to the present, I have read articles in various dental magazines and have heard discussions at dental meetings on this subject of full reciprocity in dentistry between the states. The only argument against it seems to be that of State rights being invaded. It makes one want to say, "The heck with State rights. Give the membership a much needed break."

If it is a question of State rights, then how about it being an invasion of State rights by the medical profession? If a physician who has been granted a license in his state through examination and has been in ethical practice for five years

desires to change states, he may in many cases, do so simply by sending his state license to the board of the state to which he desires to move. There are no examinations, no patients to prescribe for in a hospital, no diagnosis, no operations to perform in an operating room. He is granted his license exchange and that is all there is to it. In his profession, a person's life may be at stake, or at least his health. One medical board trusts the other board that the applicant is qualified. But we as dentists apparently trust no one.

The pharmacists can change states in the same manner physicians may. A pharmacist, if careless, might make a mistake in filling a prescription. The patient the prescription is for has but one life,

*This dentist advocates national licensure or reciprocity
between the states.*

and his life may depend on the man back of the prescription case.

In dentistry, a patient may lose a tooth by the carelessness of the dentist. That is about all he might lose. Unless he has been unfortunate in the past, he has other teeth left he can use. Of the three professions, which one is the least likely to cause the death of a patient? The dental profession, of course, but it is the one in which the practitioners of one state are the most suspicious of the qualifications of those in another.

Border Communities

Here is another argument for reciprocity. In my home state of Iowa there is a good location for a dentist in a town which is exactly on the state line between Iowa and Missouri. I looked at this town at one time with the idea of locating there but did not for this reason: The main street runs east and west. The north side of the street is in Iowa in which I am licensed. The south side is in Missouri in which I am not licensed. There was available office space on the north side but it was not desirable or modern. On the south side of the street in Missouri, there were some pleasant, modern offices. But they were in Missouri.

Often a dentist is called out to relieve a toothache, or extract for a bedridden patient or one badly

crippled, or an invalid unable to go to a dental office. If I had located in this town on the Iowa side of the main street and had received a call to attend a patient on the Missouri side and had not gone because I had no Missouri license, I would have made an enemy of that person. He would have been angry with me forever afterward and adversely advertised me as being "too biggity" to go outside of my office to a patient.

This same condition of practice exists in Texarkana, a city on the Texas-Arkansas state line. Also, in Grand Forks and East Grand Forks; the former in North Dakota, the latter in Minnesota. In all three cases it is a matter of a few feet where a man might legally practice. Isn't that a ridiculous situation?

I know a dentist who practiced in a small Iowa town for a number of years. He is trained for no vocation other than dentistry. He has a 10-year-old daughter who has a serious case of asthma. The practitioner's medical friend told him if the child was not taken to a different climate, she would die. You can guess what this dentist did. But he does not know how he is going to make a living there. He has been out of dental college so long he says he cannot pass the theoretic examinations. As for the practical examination, he said the

board demands the insertion of a gold foil restoration and he has not pounded one in in fifteen years or more; to be exact, not since gold inlays came into general use. He does not even know where his gold instruments are now. Incidentally, I do not know where mine are either.

In dental schools or colleges the insertion of gold foil restorations is still being taught. It is claimed that this teaches the students dexterity in handling instruments. Why not hand a student having an extraction case one of those old-fashioned turnkeys used a hundred years ago? No doubt it would teach the student dexterity in handling a modern forcep.

Upon going over a list of states showing the populations and the number of dentists therein, I find there are too many dentists in some states and too few in others according to the census. States in which there are one or more dental colleges seem to have too many dentists per thousand population. A student, upon graduation, usually will take the state board examination of the state in which he is graduated. This leaves the states without dental colleges too few dentists. The distribution of dentists is not equitable. Reciprocity would change that because any dentist would go where he saw he could do the best financially.

Limited Reciprocity

Iowa and Oklahoma had limited reciprocity for a number of years.

A practical examination was given (and, of course, it included a gold foil restoration). Then after a few years the two boards disagreed. The argument was nothing so serious that a little diplomacy would not have settled it satisfactorily. The result, however, was that the states do not recognize each other's licenses now. No doubt, though, each member of each board preserved his dignity. But at whose expense? At the expense of those men and women who desire to move from one state to the other. Neither Iowa nor its board gained anything. Many Oklahoma students used to come to the University of Iowa to take the course in dentistry. They do not come anymore. They go to colleges in other states. If we had a national board of dental examiners, a license from which would be good in any state, all these annoyances, discriminations, and injustices would be eliminated. Of course, a lot of board members would lose their jobs. They would lose the prestige a member of a board gains, but the monetary loss would be infinitesimal.

Even in Russia, a huge country we consider a benighted nation, a dentist can practice anywhere his services are needed. It is the same in England or in France; in any country, it seems, but here.

I know of one state, not recognizing in any way another state, in which members of the state examining board maintained a quiz course, the cost of which was \$250. If an out-of-state applicant for a

dental license took this quiz course, he was passed by the board. If he did not take it, he did not pass. A national examining board would have stopped this.

Board Examinations

A few years ago I took the examination of a board in a southern state. I will always remember two questions asked in the examination in prosthetic dentistry. One was, "Describe a 'jackie' crown." We applicants supposed the examiner had intended to say "jacket" and had written "jackie" by mistake. All applicants described a jacket crown. We were all wrong.

After the examination we asked the examiner if he had really meant "jackie." With a surprised look on his face, this examiner exclaimed, "Why don't you know what a 'jackie' crown is? I supposed you had all heard of it. I invented it myself." All but two of us were out-of-state applicants. We had never even heard of this examiner before, much less his "jackie" crown.

The other question was, "A patient with both upper second molars and both upper cuspids in place, all in a healthy condition, does not want a denture. What would you do with the case?" All but one, and he was an out-of-state applicant, said he would advise a cast removable or a fixed bridge. The one applicant from outside the state, and whose answer was correct, said he would not take the case.

It is a matter of opinion who was right. How many of you would have turned down this case in practice? It was one man, the examiner, who made the decision. We had to accept it. This, too, was another unfair question; and another argument for a national board.

The two applicants from the state in which the examination was given received their licenses even though they, too, missed both questions. If one failed in prosthetics, no license was granted. The man who would not take the case and who was an out-of-state man passed this subject. I had passed all other subjects in the examination. In prosthetics my grade was 69.75 per cent. I did not get a license because of two unfair questions.

Veterans Administration

After World War I I was appointed as a dentist to the Veterans Hospital at Omaha, Nebraska. I had only an Iowa license. At the hospital I would not have been a dentist in the Army, Navy, or Marine Corps. My patients were to be civilians like myself (ex-Servicemen). Would not that be an invasion of the sacred State rights by the federal government? By all arguments, the appointment should have gone to a Nebraska-licensed dentist. Following this line of reasoning, it would be an invasion of State rights for me to be appointed out of Iowa to the position of a dentist in a Nebraska hospital by

those in charge of such appointments. Where is the difference? The cases would be similar. A national license would have taken care of such situations.

If we are going to confine a dentist to practice in but one state, why not carry this a degree further and confine him to but one county? The dental profession took a long step forward in having outlawed advertising of prices by members of the dental profession in virtually every state. Why not

take another long step forward and remove the shackles binding a man to one state unless he takes a rigid examination in theoretic subjects he forgot twenty years ago. I would suggest free and open reciprocity with no practical examination between all states which do not allow advertising of prices by dentists; or at least a national examining board whose licenses would be good in all states.

*P. O. Box 296
Redfield, Iowa*

STATE DENTISTRY

By WM. LIGHTNER CONRAD, D.D.S.

Socialistic in origin
Totalitarian in design
Antidemocratic in principle
Threatening to liberty
Experimental in method

Destructive of freedom
Excessive in taxation
Negative in quality
Totally communistically managed
Immersed in propaganda
Shoddy in work
Trifling in research
Red tape galore
Years of experience lost

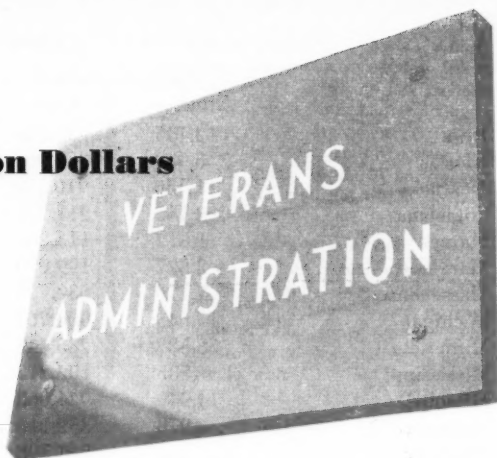
THE COVER

THE COVER features the Liberty Bell in Philadelphia. The Greater Philadelphia Dental Society's annual meeting will be held in that city, February 2-4. The photograph was supplied through the courtesy of the Philadelphia Convention and Visitors Bureau.

1949
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Fifty Million Dollars

A Year



DENTISTS IN private practice handled 90 per cent of the treatments completed during the year ending June 30, 1948, under the federal program to treat eligible veterans for service-connected dental conditions, according to a Veterans Administration announcement. Doctor Bion R. East, recently named director of the Veterans Administration Dental Service, said

\$50,231,174 was paid to private dentists. A valuation of \$5,534,657 was placed on the service given by the Administration's staff dentists.

The accompanying statistical report shows 602,617 treatment cases completed by private dentists and 420,440 completed examinations. Staff dentists completed 280,560 examinations.

| | Cases Completed | | Cases Examined | |
|-------------|-----------------|--------------|----------------|-------------|
| | Number | Cost | Number | Cost |
| Total | 602,617 | \$44,691,814 | 420,440 | \$5,539,360 |
| Alabama | 2,285 | 147,442 | 2,439 | 16,874 |
| Arizona | 680 | 35,099 | 343 | 2,758 |
| Arkansas | 3,964 | 256,860 | 2,295 | 35,136 |
| California | 26,362 | 2,354,119 | 11,159 | 158,827 |
| Colorado | 2,980 | 184,883 | 2,328 | 15,770 |
| Connecticut | 4,744 | 422,758 | 414 | 5,801 |
| Delaware | 839 | 56,329 | 263 | 2,056 |
| Florida | 5,166 | 393,755 | 2,743 | 33,767 |
| Georgia | 6,659 | 504,528 | 3,161 | 36,415 |
| Idaho | 3,251 | 217,722 | 2,570 | 32,507 |
| Illinois | 32,267 | 2,796,308 | 43,737 | 607,096 |
| Indiana | 19,811 | 1,433,445 | 7,032 | 96,610 |

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| | <i>Cases Completed</i> | | <i>Cases Examined</i> | |
|----------------------|------------------------|-----------|-----------------------|---------|
| | Number | Cost | Number | Cost |
| Iowa | 12,433 | 935,126 | 11,022 | 135,843 |
| Kansas | 5,932 | 321,964 | 3,816 | 58,257 |
| Kentucky | 11,450 | 910,552 | 11,661 | 155,408 |
| Louisiana | 3,152 | 211,239 | 2,557 | 48,637 |
| Maine | 1,872 | 113,261 | 1,397 | 19,538 |
| Maryland | 2,527 | 199,079 | 1,464 | 20,494 |
| Massachusetts | 7,770 | 630,726 | 7,954 | 111,356 |
| Michigan | 14,643 | 1,006,767 | 9,607 | 111,213 |
| Minnesota | 58,587 | 4,285,447 | 60,583 | 800,756 |
| Mississippi | 1,585 | 102,212 | 1,649 | 15,120 |
| Missouri | 14,949 | 944,068 | 10,568 | 151,295 |
| Montana | 4,978 | 352,111 | 5,345 | 72,661 |
| Nebraska | 7,838 | 544,398 | 6,270 | 73,911 |
| Nevada | 513 | 38,707 | 203 | 1,788 |
| New Hampshire | 1,977 | 118,638 | 2,038 | 28,218 |
| New Jersey | 24,499 | 1,766,925 | 4,201 | 71,543 |
| New Mexico | 560 | 44,779 | 516 | 4,221 |
| New York | 92,751 | 7,688,011 | 70,058 | 899,373 |
| North Carolina | 7,861 | 539,560 | 7,619 | 92,931 |
| North Dakota | 4,302 | 254,483 | 5,593 | 74,578 |
| Ohio | 27,438 | 2,239,482 | 16,013 | 228,348 |
| Oklahoma | 7,365 | 471,695 | 7,709 | 119,533 |
| Oregon | 6,022 | 523,465 | 1,744 | 22,820 |
| Pennsylvania | 77,040 | 4,990,937 | 33,251 | 370,425 |
| Rhode Island | 1,273 | 102,050 | 570 | 7,337 |
| South Carolina | 1,878 | 125,701 | 1,535 | 16,132 |
| South Dakota | 6,064 | 342,267 | 3,349 | 44,512 |
| Tennessee | 1,940 | 134,217 | 2,134 | 29,603 |
| Texas | 8,041 | 478,452 | 7,101 | 100,569 |
| Utah | 2,501 | 129,176 | 1,785 | 18,805 |
| Vermont | 472 | 30,458 | 66 | 796 |
| Virginia | 7,894 | 496,620 | 7,254 | 101,314 |
| Washington | 7,457 | 761,570 | 5,849 | 87,418 |
| West Virginia | 3,076 | 218,281 | 4,003 | 55,060 |
| Wisconsin | 41,338 | 2,780,600 | 17,367 | 242,334 |
| Wyoming | 1,336 | 99,956 | 1,085 | 12,983 |
| Alaska | 446 | 65,240 | 444 | 8,095 |
| District of Columbia | 6,923 | 601,409 | 3,916 | 54,780 |
| Hawaii | 3,471 | 184,770 | 1,390 | 20,303 |
| Puerto Rico | 1,455 | 104,167 | 1,270 | 7,435 |

DEAR Oral Hygiene



personnel, and high professional standards would not welcome dentists from every state in the land who had passed a national board examination. Charlatans and quacks are eager to invade such virgin territory, and who can say in the long run that the dental health of the state in question would be improved?

As for members of the Armed Forces, I know of a great many instances in which members of state boards did everything in their power to pass worthy applicants of other states who did not desire to return to their native state, or the state in which they had been practicing.

It is true that many states make it difficult for a dentist in ill health to change climates. There is a reason for that—self-protection. Why should a well-established dentist in a high and dry climate have a competitor from some other state who is coughing and sputum-laden? Why should a well-established dentist in Florida have forty old men as his new competitors, all of them in semiretirement, with slight interest in the future of the profession, and practicing only for the slight financial gain they might salvage?

No one knows what an honest poll might bring forth. No one knows whether or not there is any such thing as an honest poll. Would it be fair for a state overloaded with dentists of all types, including advertisers, to vote against a state with a lesser number of higher type men who definitely did not want them? Is that democracy?

On paper it sounds good—equal distribution of dentists in all parts of the country, higher standards, and everybody happy. Actually, it will not work. With the shortage of dentists created by the war years, few dentists are interested in settling in small towns, educating the public, and eliminating "black-market" dentistry. Only time and graduation of the enormous classes now be-

(Continued on page 86)

Against Reciprocity

Are all State rights to be taken away? Is the trend in dentistry toward nationalization and socialism?

I read with particular interest the article DENTAL LICENSING VERSUS DEMOCRACY in ORAL HYGIENE. I can say frankly and without prejudice that I cannot agree with any point offered by the author, unless it be "the right of a dentist to practice is limited to that state in which he has a license," and the statement on reciprocity.

The degrees obtained by dentists are not attained in the process of a few months, and it seems prudent in the course of several years that a student could make up his mind in which state or section of the country he desires to practice. As for a dentist of five to fifty years of successful practice, he is seldom prepared to take a state board examination unless he studies subjects such as histology and anatomy constantly. The details, of course, not applied daily are soon forgotten.

It is easy for a professional man to grasp why a state with good fees, clean

Giragi, Columbus: Dental Licensing Versus Democracy, ORAL HYGIENE 38:1559 (October) 1948.



Can You Take

Your Own

MEDICINE?

By C. L. MEISTROFF, D.D.S.

SO, YOU'RE AWAKE; and at 3 a.m., too. Feel funny? That sudden, sharp, jangling feeling in the lower left second molar reminding you of the time Jones called at the same hour. Now you are wide awake and you know for certain it was not the telephone ringing—the alarm clock going off that dragged you back to reality with jerks of suddenness.

You cannot take a breath without having icicles fall on that tooth. The things for which you recommend your patients seem to be the only remedies you know. The various tangibilities to which you object on either gingivae or teeth you are now quite prone to try; bromine seltzer, alkaseltzer, aspirin, anacardol. No good; that would be like chewing! So, you look in the medicine cabinet and find that your combination of codeine and aspirin that you had at one time has been used by your friends. There are

*Practitioner recommends that you cast yourself
in the role of a cooperative dental patient.*

drugstores open at this hour either. So you sit down and begin to do some deep thinking and you suddenly get an idea.

You call your buddy, Joe Dudd, on the telephone. He listens with one ear partly open, both eyes closed, and his mind still in a hypnotic haze. He is so sorry but his former commanding officer happened to be passing through town and borrowed his car to visit an old friend over in Chittlin Switch, and since you have no car how can he see you? Cab drivers have not the vaguest idea as to how to reach his place out in the country. A yawn, well enjoyed, and he has hung up.

Next is Bill Jiggers who is just as sorry as he can be but his office is being painted and everything is under tarpaulins. He cannot get to a thing.

Restored Tooth

Then you think. This is your "comeuppance!" You remember that three years ago old Doctor Smithers examined your mouth carefully — roentgenograms, prophylaxis, a complete checkup—and then told you that that particular tooth had been restored so much that it had better come out then. You thanked him for his cooperation, and yet you made your way to another office and had that tooth made into a repository for a king-sized amalgam and a junior-sized

silicate. It reacted for several days and then came through all right.

Then one day, about a year ago, you detected a putrefied shred of the steak from the night before; you had the tooth roentgenographed and found caries under the mesial amalgam. You had it opened up, and finally restored. Some months later a margin broke and that was patched. Not long after that you thought you had a piece of calculus on the lingual and started a personal itinerary with mirror and explorer. What you thought was tartar turned out to be hard debris in a large lingual cavity at the gingival. That was restored. When the buccal wall under the silicate gave way, you had another friend plug some silicate over a cement base and it looked like that was the last thing to be done to it—how right in a way. And it would last a lifetime; yours or the tooth's?

Doesn't it sound ironical to be afflicted with the same ailments and procrastinations against which you so sincerely advise your patients? But, after all, you cogitate, is there any physician who does not get appendicitis or mumps? Doesn't the shoemaker also suffer from holes in his soles? And the successful lawyer sometimes loses a case because of some insignificant detail. Well, so what! Even self-pity does not help.

That tooth is really popping now—so you call again. Desperately you call Henry—so you think—but his wife answers. True to her husband's welfare she follows the old family line, "Sorry, he's not in yet." What a confession! Now you know why they are always scraping.

Eccentric Dentist

You start to pace the floor; you will do anything to get that tooth out. You call old Doctor Jessup. He is the old fellow everyone calls a "long-haired quack." He is over sixty, slow, dignified, and goes his own way. His suggestions and motions at the meetings are always laughed at and pigeonholed until the next millenium. He is not a snappy dresser and, because of blonde hair, only shaves once in two days. He is no wit. Despite all these mental blackballs, you call him. He answers the ring on the second time; no, he was not asleep. He had some work on a new prosthetic idea and did not realize the lateness of the hour. "Toothache? Poor fellow, get dressed. I'll drive down and pick you up—your office or mine? Mine? OK. I'll be around shortly."

He picks you up and soon you are in his office for the first time. It is not much of a place; it needs fresh paint and new furniture. You never did approve of plain linoleum on the floor. And of all things—that rifle and machete on the wall are what he used during the Spanish-American War. Well, any-

way your mind is off the toothache. He comes back into the reception room and ushers you solicitously into the operating room. You look around with a quick, kaleidoscopic view. An old chair, vintage of 1906; first edition of a unit complete except for the radio and fan. Well, anyway, the cuspidor is clean and white. He washes his hands carefully. From the moment he places fingers and instruments in your mouth you feel at peace. Nice hand—easy, too.

You seem to disregard the old equipment and the age-encrusted atmosphere about the place. He looks and acts so fatherly and kind. You had wondered if he were modern enough to have an x-ray machine. Sure, he has. He wheels in a white enameled, square, box-like affair with overhead wires that looks like a cross between a prehistoric diathermy and a Whimhurst static machine. The film is gently placed and, amid a short eternity of crackling, popping, and buzzing, the exposure is made.

The syringe is taken out of a sterilizing jar; the anesthetic cartridge flamed and put to place. He gives you a paper cup of mouthwash which you use, and the injection is made thereafter—and does not bother you. While anesthesia is taking place he processes the films and the necessary forceps and instruments are sterilized. Nice time saver, too.

He used good judgment in extracting. Despite a patched-up crown and divergent roots, the

tooth came out in one piece. Weren't you thankful? No alveolar fracture, no torn gingivae, no lacerated corner of the mouth. He took you to his car and asked sympathetically how you felt, and told you to drop in the next afternoon so he could check on the healing. You swallowed the two tablets he gave you, went to bed, and thought quite a bit before you fell asleep.

"Lots of the boys have him wrong. He's not so bad. Only his ways are set and different. Might be like that myself at his age. Must be all right—and at 3:30 a.m., too." Could it be that you are beginning to see a light? Trying to turn over a new leaf without too much transition? It could be—things like that happen, you know.

113 East Grace Street
Richmond, Virginia

SELECTIVE SERVICE RAISES DENTAL REQUIREMENTS

BECAUSE OF the shortage of dentists in the Armed Forces, the dental requirements for inductees into the Army have been raised. During and subsequent to World War II, men who had no natural teeth could be accepted. Now inductees must have at least eight upper and eight lower teeth.

A wartime survey showed that for every 100 inductees, approximately one hundred extractions, fifteen dentures, and three hundred fifty restorations were required. After roentgenographic examinations were made, another 650 restorations were required for the group.

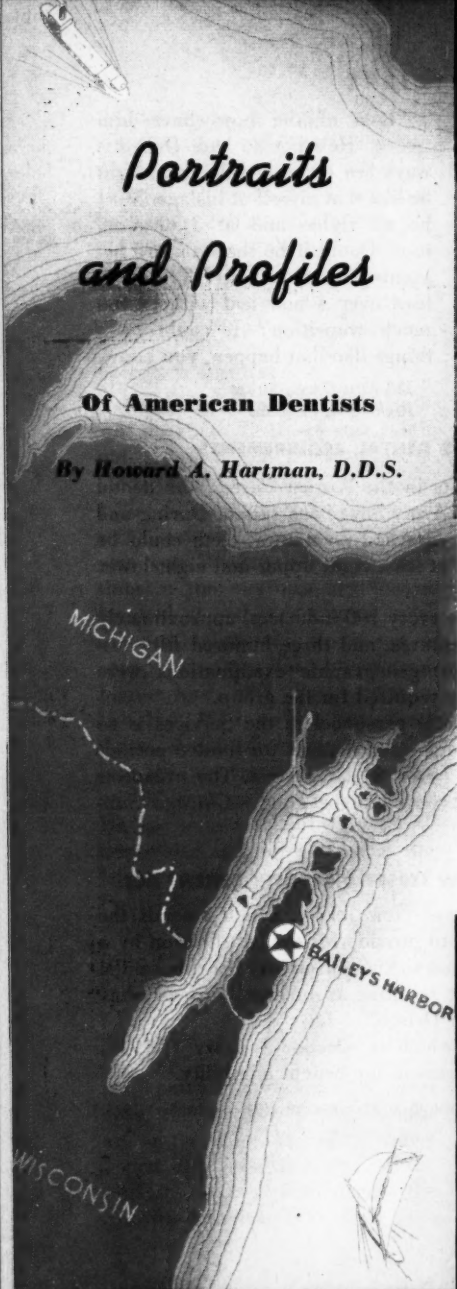
The shortage of medical and dental personnel in the Services is so acute that legislation to draft physicians and dentists for limited periods of duty probably will be proposed in the 81st Congress. The prospects for enactment of such a law are believed to be good.—*Chicago Sun-Times*.

DENTISTS TO CERTIFY UNDER NEW JERSEY DISABILITY BENEFIT ACT

SENATE BILL No. 392 in the State of New Jersey, which amends the Temporary Disability Benefits Law to provide for the certification by a dentist to the illness of a patient so that sickness-disability benefits can be paid for involuntary unemployment resulting from dental disease, has been passed and signed by Governor Driscoll.

The original Cash-Sickness Act, which is effective January 1, 1949, failed to include dental illness as a reason for benefit eligibility.¹

¹Golden, F. L.: New Jersey Overlooks the Dentist, *ORAL HYGIENE* 38:1374 (September) 1948.



Portraits and Profiles

Of American Dentists

By Howard A. Hartman, D.D.S.

Valy Menkin, M.D., of Temple University, Philadelphia (left); and Roger E. Huntington, of Evanston, Illinois.

The Midwest Seminar of Dental Medicine

**Maxwelton Braes,
Baileys Harbor, Wisconsin**

B. F. Dewel, of Evanston, Illinois (left); and Jacob Lippert, of Chicago.





Above: Melvin H. Knisely, Ph.D., of the University of South Carolina, Charleston, (at far right) speaks to a group of seminarians on physiology of the blood.



Hermann Becks, of the University of California, Berkeley, speaking.



Isaac Schour, University of Illinois, Chairman of the Seminar.



Seminarians at mealtime.

Left to right: Raymond J. Thorsen, of Winnetka, Illinois; Raymond Perschbacher, of Appleton, Wisconsin; Frank M. Wentz, of Chicago; and Russell C. Wheeler, of St. Louis, Missouri.

Left to right: R. H. Stearns, of Oshkosh, Wisconsin; Ralph E. McDonald, of Indianapolis; and Herbert K. Cooper, of Lancaster, Pennsylvania.

Above: Isidore Gersh,
Ph.D., of the Univer-
sity of Illinois, speak-
ing on histochem-
istry.

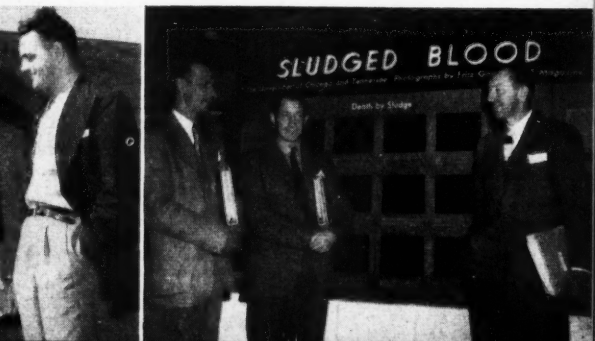


Right: Professor
Henkin (center) dis-
cusses modern con-
cepts of inflamma-
tion with Ronald D.
Emslie, of London,
England; and Henry
M. Rosenberg (right),
of Chicago.



Bottom: (left to
right): Robert G.
Kesel, Chicago; Paul
B. Bass, Wilmette, Il-
linois; and Henry Q.
Conley, Evanston, Il-
linois.

Bottom right: (left
to right): Henry
Glupker, of Chicago;
Emslie, of London,
and George Matula,
of Chicago.



LOOKING BACKWARD



**How does this dental office
of fifty years ago compare
with your office?**

By RICHARD J. MORG, D.D.S.

WHEN I WAS a boy-dentist, nearly fifty years ago, I knew the owner, the proprietor, the dentist, of a dental parlor in the heart of the shopping district in New York City. Gold letters brightened a showcase at the street door. Inside the case were plush cushions on which reposed gold crowns, models made of alabaster, beautiful specimens of bridges, pretty pink

celluloid dentures with pearly white teeth. These dentures, when you rubbed them on the sleeve of your coat, gave forth an odor of gum camphor. There also were the gum blocks, sections of three teeth set in pink porcelain. If you were clever, you could grind close joints and make a set of teeth on vulcanite. The joints barely showed when wet with saliva and in the patient's mouth. There was also a framed list of prices—full dentures, \$5 and up; extractions, 50 cents; "plates" repaired while you waited, \$1. A special sign, in a frame, read: "Fresh Gas, Made Daily."

This is the way it was made. Crystals of ammonium nitrate were

placed in a Florentine flask and a rubber hose connected to it. The neck of the flask was drawn out so that you could fit a hose to it. This led into a tank of water. The rubber hose end was above the level of water, and over this an empty inverted tank was placed. This was to gather and confine the gas. Gentle heat from a Bunsen burner applied to the flask containing the crystals released the gas. The water absorbed the ammonia formed and also any nitric oxide that formed. From the tank the gas was piped to the wall near the dental chair. That was the source of supply for "Laughing Gas." The patients got plenty. Yes, they were crowded with gas and the treatment was painless.

When I was assigned to operate on an elderly woman, she would usually say, "Why you are just a boy—and a dentist?" I was dubbed "The Boy-Dentist." I had my degree; I needed money. It was my first job, and it paid \$25 a week and commission.

There was a mechanic at \$15, a boy at \$5, and a so-called "Lady Attendant" who was paid \$10 and commission. There was a uniformed Negro who stood at the door all day long and mumbled, "Painless Dentist." What he got for recompense, I do not know.

I wore my best suit, a cutaway and striped trousers, and patent-leather shoes. A white coat was unthinkable—you did not want to look like a barber. There was a brass cuspidor in the reception

room. It reposed on a cut-out circle of oilcloth, a guard for those who missed. The room was furnished with a horsehair couch for patients recuperating from gas, heavy red carpet, rockers of generous size, easy chairs, oil paintings, lace curtains at the windows, ornaments on the mantelpiece, and a stovepipe under it that led to the ornate nickel-plated self-feeder. What a homey place it was!

The elderly women liked the young dentist. He knew all the latest college techniques. To some of the men, I appeared too young. There were those who wanted the whiskered man; he had the years of experience.

You never extracted a tooth if you could induce the patient to keep it. That is where the money was, if you could keep the patient coming back for treatment.

There was a trend in fashions; gold laterals gave a look of prosperity. If the patient wanted it, why not put on a gold crown for \$5? Better ones ran up to as high as \$10.

There were many transitions from the advertising man to the ethical dentist. As a school for experience, and if you needed the money, the advertising dental office was a nice start. At your leisure you could look around for an office location. The dental depot and a downpayment started your office equipment, and the installment house took care of the furnishings. If you had enough money to pay three months rent,

you could start practicing.

There was no income tax. Teeth with two platinum pins cost from 10 cents to 15 cents, and sets of pinless teeth, fourteen of them,

cost 50 cents. The best theater tickets cost \$2. What a wonderful time \$10 gave you!

*P. O. Box 2
Rhinecliff, New York*

PHYSICIAN REPORTS ON BRITISH HEALTH PLAN

"SOCIALIZED MEDICINE in Britain will collapse within five years."

That is the opinion of Doctor Lester Carson Spier, Chairman of America's National Council in Group Practices who has been in Britain studying the government's health scheme.

"Britain hasn't the money for socialized medicine," Doctor Spier reports. "Even America couldn't find enough.

"The standard of British medicine is nowhere near so good as it should be. And instead of spending money on research for improvement, the British government is subsidizing poor and inadequate medical care. The average American wouldn't stand for the result. Britons must.

"I went to Britain to find out the truth," Doctor Spier said. "I saw that soon the lack of opportunity, and restrictions upon earnings under socialism, will react severely upon the type of men entering medicine—then on medicine itself. There is a drop in the level already. Limitations imposed through socialization remove all the incentive. Physicians are human. How can you expect the best type?

"Under the scheme Britain's physicians soon won't be distinguishable from any other Civil servants.

"When I was in England I saw signs of the development of a lively black market in physicians and medicines under socialism. And at least a preferential treatment given by some physicians to richer patients who could afford to pay extra.

"I saw that under the health scheme many people, having paid their contributions, won't go to a private practitioner now, even if they can afford it. They swamped the outpatients' departments—as they have a perfect right. But there are not facilities for handling two or three hundred outpatients per physician daily, instead of the usual twenty or thirty."—EVELYN WEBBER, *London (England) Evening Standard*.

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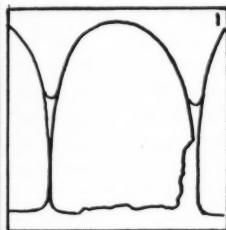
TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.

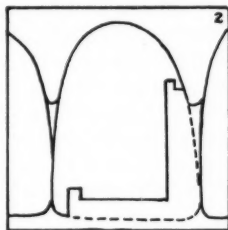
Drawings by Dorothy Sterling from sketches by the author

Restoring Incisal Angle

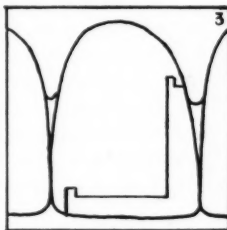
By George P. Carroll, D.D.S.



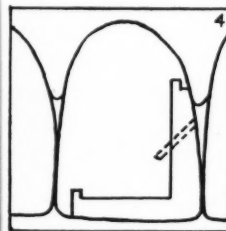
Upper central with fractured incisal angle. (In this technique an acrylic inlay and pin may be used but will not be as durable as the gold.)



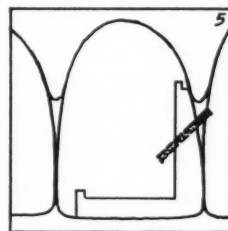
Prepare cavity with flat seats, definite angles, beveled margins, and slight pits drilled in incisal angle and pulpal seat.



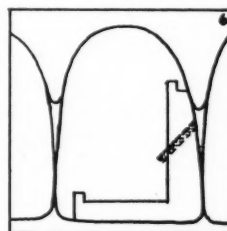
Cast inlay in the usual way. Try in the cavity. Burnish and polish.



With a sharp #6 round bur, drill through the inlay and about 1½ mm. into the tooth at an incisal angle. *Be very careful not to drill into the pulp.*



Try a piece of round, gold clasp wire (same size as hole made by #6 bur) in the hole in inlay. If hole is too small, ream it with a tapering cross-cut bur, but keep the fit snug.



Remove inlay. Dry cavity. Place *very thin cement* in tooth cavity. Seat inlay and *immediately* drive the wire into hole in inlay and tooth. When cement has set, cut wire with disk. Polish.



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

COMPULSORY HEALTH INSURANCE NEARER

WE ARE CLOSER to compulsory health insurance today than at any time in the history of the country. Although bills calling for compulsory health insurance have been introduced in the Congress consistently over the last sixteen years, not one came close to becoming enacted into law. Mr. Roosevelt, the champion of Social Security legislation, put through the old-age and survivor's benefits and unemployment features of Social Security. He did not press hard for compulsory health insurance. Mr. Truman, however, is an advocate of such a system.

A foreshadowing of the sequence of events in the effort to establish a federal health insurance system is projected in the report¹ made by the Federal Security Administrator, Mr. Oscar R. Ewing, to President Truman on September 2, 1948:

"The logical sequence of events for accomplishing these ends would fall in this pattern:

PHASE ONE:

Federal legislation to settle the basic policies of a system of government insurance and to decide important details; and to provide for a three-year 'tooling-up' period before the date on which insurance benefits are made available.

PHASE TWO:

The tooling-up period, during which procedures would be worked out cooperatively by professional groups, localities, with individuals and groups providing medical services; and the machinery for actual operations set up.

¹Ewing, O. R.: *The Nation's Health, a Ten-Year Program*, a report to the President, Washington, D.C., Federal Security Agency (September) 1948.

PHASE THREE:

Operations begin, services are provided up to the ceiling set by resources as they exist at the time.

PHASE FOUR:

Expansion of services, as the accelerated increase and improved distribution of medical manpower and facilities lift the ceiling, until comprehensive services are available to everyone, everywhere in the country."

When Mr. Ewing made his 186-page report to Mr. Truman on September 2, most people looked upon it as an interesting document but not as a blueprint for the Nation's health. Few expected Mr. Truman to be in a position to sponsor a long-term health plan. With his election, however, and with the support of organized labor which has favored compulsory health insurance for years, we may expect to see the blueprints of September, 1948, become the laws of 1949.

Since the election there has been much irresponsible talk regarding so-called "state medicine." In any system of a national health program there should be the following provisions and guarantees:

"The law should give equally explicit guarantees to the members of the professions who provide services, including the right to participate in the plan or not, to act individually or in groups, to accept or reject patients who choose them, to retain control of professional aspects of professional service, to choose the method of payment for services rendered, to negotiate rates or amounts of payment and other matters through representatives of their own choosing, to make complaints or appeals before appropriately constituted committees, and to turn to the courts for review of administrative decisions. Such guarantees would preserve the essential freedoms of the professions and assure that they could not be 'regimented' by administrative officers."

This quote is from Mr. Ewing's recommendations to the President. The members of the dental and medical professions hope we can depend on those recommendations. We should be prepared to fight for those guarantees under any kind of federal health program.

Edward J. Ryan

Dentists in the NEWS



Los Angeles (California) Examiner: From the wheel chair to which he has been confined for two years, Doctor Edward Grubin acts as a dental consultant for the Veterans Administration during the daytime and a night-club entertainer at night.

While serving in the Philippines as a Captain in the Army Dental Corps, Doctor Grubin was stricken with poliomyelitis. He has not walked since.

Not long ago this dentist wheeled himself into a Hollywood drugstore and found working behind the soda counter his former show-business partner, Tony Santro. The two had worked together in night clubs before the war. Doctor Grubin earned his way through Temple University in Philadelphia in this way.

The former partners are now back together in show business.

New York (New York) Daily Mirror: Doctor Charles Dillon Stengel, known to the sports world as "Casey" Stengel, has been signed by the Yankees as their manager for the next two years. This 57-year-old former dentist is the fifth manager the club has had in three years.

Stengel started his organized baseball career as an outfielder for Kankakee of

the old Northern Association in 1910. Since then he has played for Brooklyn, Pittsburgh, Philadelphia, the Giants, and the Braves, and has been with various minor leagues.

He is a resident of Glendale, California, now, and owns oil lands in Texas, a theater, and a hotel.

Durango (Colorado) News: Many years ago Doctor H. C. Pollock, Sr., a St. Louis, Missouri, orthodontist, spent his summers conducting a boy's camp called Rancho Mesa Verde at Allison, Colorado. Once when he and his boys were caught in the mountains in a rain-storm, they stopped at Teelawuket Ranch for shelter. Although they asked only for space in the huge barn, they were fed and lodged with true western hospitality. Doctor Pollock was greatly impressed with this place and later formed the Rancho Mesa Verde Company, of which he is the principal stockholder, and in 1927 bought Teelawuket (the Ute Indian name for summer home). It is located in the colorful San Juan Basin of the Colorado Rockies.

Teelawuket Ranch originally consisted of only one small log cabin which was the homestead of Jim Graham. This building still stands near the main lodge and is the Ranch tool house.

The next owner of Teelawuket was "Coal Oil Johnnie" Kirkpatrick who owned the coal and oil concessions of the whole area. In 1895 he built a large, two-story summer house which is now Teelawuket's main lodge, and a huge log structure for a recreation hall which is now the Ranch dining room.

The present owners purchased Teelawuket from Kirkpatrick. They have built a new recreation hall with a great circular fireplace in the center of the room. The Ranch can now house sixty guests in modern comfort.

It is located twenty-two miles north of Bayfield, Colorado, in Pine River Canyon. The road from Bayfield is graveled except for the last three miles which wind along the edge of a crystal

stream into a great meadow of virgin grassland. In the center is the Ranch. Horseback riding, fishing, and hunting are favorite sports at Teclawuket which is now managed by Doctor Pollock's son, Carlyle, Jr., who is also a dentist.

Time: Wyoming's Lester Hunt, an affable 56-year-old dentist, moves from the Governor's chair to the Congress. He defeated Republican incumbent



Senator Edward V. Robertson in an out-and-out popularity contest. A good rider, good shot, and terrific campaigner, Doctor Hunt favors repeal of the Taft-Hartley law, more reclamation projects for Wyoming's stockmen. Hunt has served two terms as Governor of Wyoming and before that was Secretary of State. (See October PICTURE OF THE MONTH.)

Boston (Massachusetts) Herald: Doctor Percy R. Howe and Doctor Kurt H. Thoma have been elected fellows in dental surgery by the council of the Royal College of Surgeons of England.

This month's awards for items published in DENTISTS IN THE NEWS have been sent to:

Ellen Saunders, 1049½ Overton Street, Los Angeles 15, California.

Sarah Ginsburg, 1180 Gerard Avenue, Bronx 52, New York.

Philip Brady, Box 92, Sturbridge, Massachusetts.

Mrs. George Straman, 105 East 41st Street, Covington, Kentucky.

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, which is published in *Dentists in the News*, we will send promptly a crisp, new one dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Doctor Howe, Director of the Forsyth Dental Infirmary for twenty years and a Past-President of the American Dental Association, is noted for his research in the effects of vitamin deficiencies on the teeth.

Doctor Thoma has been oral surgeon and chief of the dental service at the Massachusetts General Hospital. He is the author of two widely used dental textbooks.

Both dentists are on the faculty of the Harvard School of Dental Medicine.

Cincinnati (Ohio) Times-Star: A Covington, Kentucky, dentist, Doctor John E. Sullivan, who founded the Kentucky Crippled Children's Society, has been awarded a bronze plaque in recognition of his services to the handicapped children of Kentucky. The award was presented at a testimonial luncheon given by the Covington Rotary Club.

More than any other person, Doctor Sullivan, under the auspices of the Covington Rotary Club, was responsible for the organization of the Society and the carrying forward of its program throughout the State. He was the first President of the Society which finances and sponsors the prevention, care, and treatment of all types of deformities in children. His efforts in behalf of the movement have been continuous for more than a quarter of a century.



Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Punctured Blood Vessel

Q.—I have been practicing over forty years and I had a condition develop this week that I never before saw occur. I should like to know the reason for it and if it could have been avoided.

I extracted an upper right second molar for a patient about thirty years old. By the time I had extracted the tooth, swelling began under the eye and extended over the entire right side of the face. I gave him penicillin and the next day his face still was swollen badly and was sore to the touch. He had no temperature.

I should like to know why such rapid swelling occurred?—P. B. V., New York.

A.—I assume that you made a second division or infiltration nerve block before extracting the maxillary second molar. In making the block you probably punctured a blood vessel and drove the blood into the tissues. If you have never

had a similar experience, you have been most fortunate, for it is not an extremely uncommon occurrence. There is no sure way to avoid such a condition, although in skillful hands it does not happen often.—GEORGE R. WARNER.

Denture Retention

Q.—I have a patient with an upper denture that I have made or rebased three times. When I first insert the denture, and so long as the mouth is dry, it stays in place with good suction. As soon as the patient uses it, however, he says saliva flows under his nose and the denture becomes loose.

I would not think much of this if it were not for the fact that another dentist made him two dentures and I have made or rebased three times with the same complaint. Have you any suggestions?—D. S. L., Kansas.

A.—A layer of saliva between the denture and the membrane of the mouth is desirable to provide adhesion between the two surfaces in apposition as two pieces of plate glass adhere with a film of water between them. If too much saliva accumulates above a denture, it should be easy for the patient to remove the excess by a sucking action. There are no saliva ducts under the nose, and it would seem that this patient must just have the notion that saliva flows under his denture at this point.—V. CLYDE SMEDLEY.

Sodium Citrate

Q.—Will you please tell me the name of the chemical which, in aqueous solution, dissolves plaster of Paris?

A.—The answer to your ques

tion is: a saturate solution of sodium citrate.—V. CLYDE SMEDLEY.

Fractured Jaw

Q.—I have a patient who would like to have some questions answered concerning a fracture of his jaw.

During a fight, his lower jaw was fractured. The blow was on the right side in the area of the bicuspid.

This caused a displacement of the mandible inward and downward. The cleavage took place at the first molar and that was the segment that went down. At the same time, there was also complete cleavage in the cuspid area on the left side. This left a movable segment which extended from the left lateral to the right second bicuspid.

The questions he would like answered are:

1. Would it take a hard blow to cause this fracture, or could it be caused by a normal, well-placed blow?

2. Since the person who struck him was 4 inches shorter than my patient, could this fracture be caused by a blow thrown upward or must it be a blow that was thrown downward? My patient contends that the man hit him while running toward him with his hand raised above his head.

3. Neither he nor I can explain the fact that with a blow hard enough to break the mandible, there was no bruising or bleeding of the chin.—M. J. S., New York.

A.—It does not take a hard blow measured in terms of foot pounds of energy to cause a fracture when conditions such as the direction of the blow, speed, timing, and size and texture of the bone involved are right. The fracture could have been caused by a blow coming from either up, down, or straight back, and such fractures often happen without becoming compound.—V. CLYDE SMEDLEY.

European Dentist

Q.—I am writing to a Hungarian who has been an oral surgeon for ten years. He wants to come to this country. He desires to practice, of course. Would he have to go to school here and pass the state board examinations? I shall appreciate any information you might give me.—F. W. S., Oklahoma.

A.—It would no doubt be necessary for your Hungarian friend to secure both his United States citizenship and a degree from a recognized dental college in this country before he would be permitted to take a state board examination, which he would have to pass to be eligible legally to practice dentistry in Colorado.

The requirements could vary somewhat in different states, but probably not enough in any state to meet his needs or desires.—V. CLYDE SMEDLEY.

Thumb Sucking

Q.—Can you please tell me what to use to stop a child from sucking his thumb or finger? The parents have used tape on the fingers and dipped them in some solution they obtained from a physician but it does no good.

The parents also said that they had read an article in the paper saying that it did not make the teeth crooked if the child sucked his finger only while the deciduous teeth were present. In other words, the child could suck his finger with impunity until the permanent teeth arrived; all of which sounds silly to me. What do you think about it? It seems to me sucking the finger would have a tendency to move either the deciduous or permanent teeth. At least it would spread the arch.—H. J. R., Illinois.

A.—In regard to a child sucking

its finger or thumb, there is a difference of opinion. It is felt by some that sucking a finger or thumb is evidence of a natural instinct and to prevent a child forcibly from doing it is harmful.

In my experience most children can be reasoned with or kindly influenced to give up thumb or finger sucking, and it seems to me that this is the best method of breaking the habit.—GEORGE R. WARNER.

Deciduous Teeth

Q.—A short time ago a patient of mine brought to my office her young son, age 16 months, who had fractured one of the central incisors at the gingival line with the resulting exposure of the pulp.

I have made inquiries of local dentists and have received the following suggestions for treatment:

1. Extract
2. Canterize the stump with silver nitrate
3. Force soft zinc oxide paste into the pulp chamber
4. Leave it alone.

I should appreciate your advice as to the manner in which a case of this type can be treated.—V. M. O., New York.

A.—With a deciduous central broken off at the gingival line, it would be best no doubt to extract the root. If there is enough tooth left to support a band, it would be best to fit an orthodontic band and cap the pulp with sedative cement.—V. CLYDE SMEDLEY.

Chewing Gum

Q.—I have a patient, a 27-year-old woman, the mother of four children, who cannot chew gum as it dissolves in her mouth within five to ten minutes.

This patient has had radium treat-

ments for bleeding of the tongue. She has only the lower anterior teeth in her mouth.

Could you please inform me if you know any cause which tends to dissolve the chewing gum?—B. L. C., New York.

A.—If you mean that the chewing gum actually dissolves, that is, it changes to a fluid, we cannot understand it or offer an explanation. If it simply fails to work into a mass, but instead breaks up and becomes granular, it could well be because of the lack of natural teeth and the patient's inability to work it from cold, hard gum into a warm, coherent mass.—GEORGE R. WARNER.

Fracture of the Maxilla

Q.—I have a patient, a young married woman, who about two months ago had an accident causing a transverse fracture of the maxilla. The fracture line was approximately at the apexes of the teeth.

The articulation is good, but I tested the remaining teeth a few days ago for vitality and the test was almost negative. The upper arch was loose and pendant.

What has been your experience as to such cases retaining vitality? I am making a partial denture to supply the missing five anteriors temporarily.—F. S. W., Kansas.

A.—I have had two cases of fracture of the maxilla and in each case the teeth remained vital. I would seem wise to proceed as you have planned. If, after the fracture is healed, the teeth prove to be nonvital, you can then remove them safely. The present failure to respond to vitality tests may result from the traumatizing of the tissues.—GEORGE R. WARNER.

Missing Incisors

Q.—I have a patient 13 years old who lost the lower four anterior teeth. Please advise me regarding the best way to restore them. A fixed bridge would be too large for newly erupted cuspids.—L. B., Illinois.

A.—At present it would probably be best to restore these missing incisors as a small partial denture, which no doubt could be supported or retained by light embrasure wire clasps on the cuspids or first bicuspid.—V. CLYDE SMEDLEY.

Antrum

Q.—A roentgenogram of a patient, a man 20 years of age, is enclosed. Two years ago the antrum was entered to remove the lingual root of the upper left first molar.

The patient at present has no unusual symptoms with the exception that he says he "imagines" a slight discharge from the region of the upper left first molar.

The external opening does not seem to be entirely closed, but on gentle probing, the antrum cannot be entered.

May I have your opinion on the roentgenogram? I am concerned mainly as to whether complete closure has been affected and the antrum is in a healthy condition.—A. T., Illinois.

A.—Your roentgenogram is too dim to be of much diagnostic value. There is, of course, little or no bone separating the floor of the antrum from the depression in the socket area.

Absorb all the free moisture from the area with cotton or absorbent paper; then massage the area with a milking motion to see if any discharge can be demonstrated. If not, it should be safe to

assume that there is no opening into the mouth. If the patient continues to have discomfort, you no doubt should send him to a nose and throat specialist.—V. CLYDE SMEDLEY.

Edentulous Mandible

Q.—I am enclosing two roentgenograms of the lower right cuspid and bicuspid region of an edentulous jaw. This woman had all her teeth removed at one time about fifteen years ago. She has worn vulcanite dentures the last fifteen years. I recently made her upper and lower acrylic dentures.

She has no lower ridge at all and has never been able to use her lower denture, primarily because of a sore spot that develops in this lower right bicuspid region. She has a blue streak under the mucous tissue. I have seen these same streaks in many mouths, and I never thought they were causing any difficulty. What is your opinion on this, and what causes these bluish streaks?

I can see nothing in these two films to warrant opening up the tissue in this area. I should like to have your opinion.

This sore area does not seem to disappear even though the lower denture has been left out. I am at a loss to know what causes this sore area, and why it does not heal when the lower denture is not being worn. Any help you can give me on this will be greatly appreciated.—B. A. D., Nebraska.

A.—The bluish appearance of the soft tissues in your patient's edentulous mandibular ridge is probably caused by the two small pieces of metal, presumably amalgam.

I have encircled an area in the bone which may account for the soreness of which your patient complains. This is not normal bone. I believe you would be justi-

fied in opening the bone and doing an exploratory operation. The area shows more clearly in the roentgenogram which was placed with the long axis vertical.—GEORGE R. WARNER.

Space Maintainer

Q.—I have a patient, a young girl 8 years of age, for whom the upper right deciduous cuspid had to be extracted. The patient's mother wants a space maintainer placed. Would it be advisable to band the first and second deciduous molars, and, from the bands send a spur to the upper right permanent lateral? Or would you advise leaving the space alone?—S. B., New York.

A.—It has been the experience of many odontologists that in the case of premature loss of the maxillary anterior deciduous teeth, there is little if any tendency to loss of space. This would be especially true in the case of an 8-year-old.

If the mother does not like the appearance of the space, the cuspid could be supplied on a small, removable acrylic denture. This would not interfere with the other teeth and would give a good appearance.—GEORGE R. WARNER.

Hypertrophied Tissue

Q.—I have a patient who has an inflamed area on the palate from an old denture. Can that be cured by placing a new denture? What do you suggest?—C. H. E., Minnesota.

A.—I have been able to correct several such cases as this by filling the vacuum chamber in the old denture with hard wax. This wax may have to be renewed a time or two, but eventually the hyper-

trophied tissue that has been drawn or sucked down into the vacuum chamber will disappear when the old denture can be replaced.—V. CLYDE SMEDLEY.

Gagging

Q.—I have, for the first time in my practice of thirty years, a patient who cannot wear a lower denture because of gagging. He can wear the upper denture and did wear a lower partial with the cuspids in place without any discomfort.

I made him a full lower denture, but any way I fix it he cannot wear it. He says it fits well on all parts of the ridge.

Is there anything that I can do to help this patient, or is it a condition he must overcome himself?—L. D. H. Idaho.

A.—When you have provided a lower denture that does not extend below the mylohyoid ridge and that provides a reasonably close adaptation and does not crowd the tongue unduly, I think you are justified in telling the patient that it is up to him to break himself of the gagging urge. Repeatedly massaging his throat or the sides of his tongue with his finger should in time make the denture feel comfortable or acceptable in comparison.—V. CLYDE SMEDLEY.

Decalcification

Q.—I have a 13-year-old boy coming to me with decalcification of the two lower second molars which have been in place only one year. These are carious teeth and the enamel may be removed with little more than fingernail pressure.

What would you advise in the treatment of his case?—G. J. P., California.

A.—In a similar case we restored the carious teeth with amal-

gam and did nothing for the decalcified enamel which gradually hardened. We lost track of the case, but it was all right for the year or two that we followed it.

If I were to have a similar case now I would still restore the carious teeth with amalgam and saturate the decalcified enamel with ammoniacal silver nitrate. Then when enough secondary dentine had formed I would cover with some type of crown.—GEORGE R. WARNER.

Burning Sensation

Q.—I have a patient who has worn full upper and lower dentures for a year. Since she has had these dentures, she has complained of a burning sensation only on the right side of the tongue.

We rebuilt the lower denture recently because of the loss of vertical dimension. While this was being done, the burning sensation ceased entirely. After setting the lower denture, the patient complained of a burning sensation only on the right side of the tongue.

Would impingement on a nerve cause this? Where would one look for this pressure?

I shall appreciate any suggestions that you may be able to give me.—R. B. A., Kansas.

A.—This burning sensation of the right side of the tongue may result from nerve pressure over the mental foramen, along the lingual ridge, or on the sublingual soft tissue, since the lingual nerve sometimes has branches in all of these areas.

You should be able to locate the mental foramen by palpating with a finger tip in the region of the first or second bicuspid. Relieve generously over this area. If the burning sensation still persists try next to locate uneven or undesirable pressure along the lingual border or along the lingual side of the ridge by the use of disclosing wax.—V. CLYDE SMEDLEY.

X-Ray Exposures

Q.—In doing root canal therapy I sometimes need a number of roentgenograms. Please let me know how many roentgenograms can be taken of the same tooth without endangering the patient's health. Our average exposure time is three seconds.—J. A. C., New York.

A.—Without knowing the focal film distance you use in your x-ray exposures, the K.V.P. and milliamperage, the interval between exposures, one cannot lay down a rule of safety.

I knew of one case in which a mandibular cuspid being treated prior to root canal filling required a number of exposures with the result of the beard on the chin being lost. Fortunately the beard grew again in a few weeks. I have known of no other cases in which any damage, local or general, resulted from checking root canal therapy, even when the cases were difficult and required at least six checks.—GEORGE R. WARNER.

SO YOU KNOW SOMETHING ABOUT DENTISTRY!**ANSWERS TO QUIZ LII**

(See page 47 for questions)

1. (b) 40 per cent. (The Michigan Workshop on the Evaluation of Dental Caries Control Technics, J.A.D.A. **36**:16 [January] 1948)
2. (c) white deposit about the necks of teeth and free margins of the gingivae. (Hill, T. J.: Oral Pathology, 3rd Edition, Philadelphia, Lea & Febiger, 1945, page 101)
3. Excessive number of teeth. (Hill, T. J.: Oral Pathology, 3rd Edition, Philadelphia, Lea & Febiger, 1945, page 154)
4. (a) sodium barbital, (b) phenobarbital, (c) pentobarbital sodium, (d) oral sodium, (e) neonal, (f) hexobarbital. (Accepted Dental Remedies, 13th Edition, Chicago, American Dental Association, 1947, pages 25-30)
5. True. (Accepted Dental Remedies, 13th Edition, Chicago, American Dental Association, 1947, page 191)
6. (a) carcinoma. (Cahn, L. R.: Signs and Symptoms of Intraoral Cancer, Year Book of Dentistry, 1947, Chicago, Year Book Publishers, page 15)
7. (c) less. (Phillips, R. W., and Drexel, A. B.: Importance of Mercury-Alloy Ratio to Amalgam Fillings, J.A.D.A. **34**:451-459 [April 1] 1947)
8. Yes—such bone has a moth-eaten appearance. (Cross, Sydney: Endocrines, Amer. Jour. of Orth. **34**:426 [May] 1948)
9. A minimum precious metal content of 83 per cent, a Brinell hardness number of 40 to 75, a low yield point and a high elongation. (Tylman, S. D.: Crown and Bridge Prosthesis, 2nd Edition, St. Louis, C. V. Mosby Company, 1947, page 748)
10. (a) twice as frequently as. (Burket, L. W.: Oral Medicine, Philadelphia, J. B. Lippincott Company, 1946, page 339)

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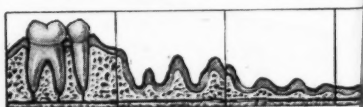
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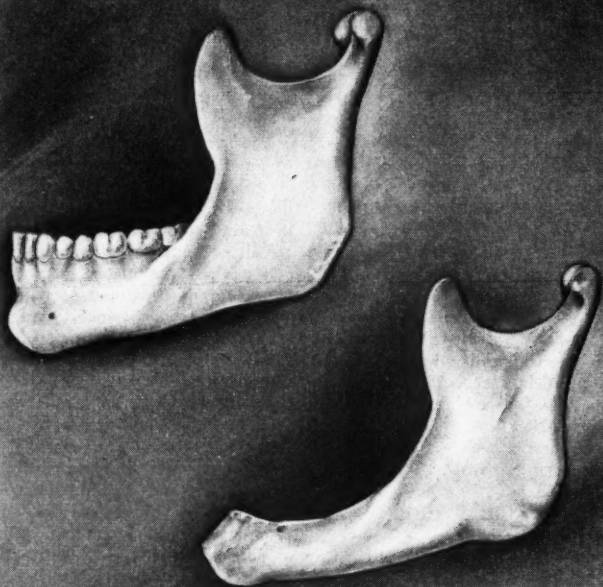
Shrinking Alveolar Process

Inasmuch as denture stability is closely associated with well-defined ridges, frail alveolar ridge formation resulting from alveolar ridge resorption (or even complete resorption of the alveolar process), presents a progressively difficult problem in the construction of stable dentures. This problem is quite often aggravated by flabby, hypertrophied, yielding alveolar tissue falling over the area to be used as a denture foundation.²⁵ This condition may be either static or progressive, depending upon the rate of resorption which is affected by such factors as extraction of teeth, denture pressure, neglected oral hygiene, failure of patient to report for adjustment at regular intervals, general systemic condition of patient, etc. In addition, the atrophic changes constantly occurring in the alveolar process present a continuing problem to the prosthodontist in maintaining satisfactory retention of dentures. This problem may be solved in great measure by the judicious prescription of Wernet's Powder during the period of resorptive change.

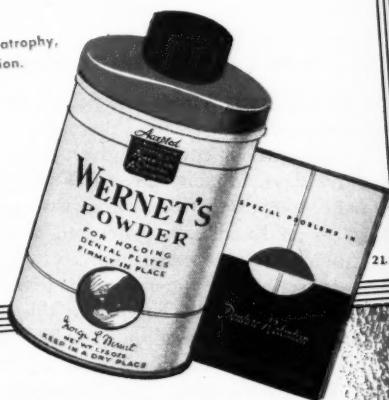
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DEAR ORAL HYGIENE

(Continued from page 59)

ing processed will improve that status. New schools are being opened, old ones are being enlarged, and in time the standards and ratio will work out themselves.

We are not in violation of any part of the Constitution. That document was framed with the idea of a strong state and an advisory central government. Why throw us in direct comparison with the medical profession? Certainly we work in close cooperation, but at the same time we are an entirely different profession. Let them work out their own destiny. We can work out ours.—WALTER C. STOUT, D.D.S., Box 219, Ennis, Texas.

For Reciprocity

Congratulations on the article DENTAL LICENSING VERSUS DEMOCRACY¹ by Columbus Giragi of *The Arizona Times*.

The Armed Forces are seeking dental officers frantically on a reserve extended active-duty status, augmented by eligibles from the Civil Service lists, when in reality public and private agencies are all well augmented by well-qualified and anxious candidates. Over one-half of the seventy thousand dentists in the United States are concentrated in six states comprising New York, Pennsylvania, Ohio, New Jersey, Illinois, and California.

What few opportunities do exist in the remaining forty-two states, possessions, and territories are limited by restrictive state board measures which set up expensive and prohibitive barriers.

The problem is obviously not one of professional shortage in any field but one of adequate and proper distribution.—RUFUS R. BEARDSLEY, D.D.S., 14683 Roscoe Boulevard, Van Nuys, California.

OHIO STATE UNIVERSITY ANNOUNCES POSTGRADUATE COURSES

DURING THE Winter and Spring Quarters of 1949 the College of Dentistry of Ohio State University is offering a series of postgraduate courses. Each course is given to groups of ten students for five consecutive days, Monday through Friday. The charge is \$50 per course with the exception of oral surgery which is \$100. Veterans may have their fees paid under the provisions of the G.I. Bill of Rights if they present their Certificates of Eligibility when they register for the first time. A course in oral hygiene will be given from January 31 to February 4 for dental hygienists. The fee for this course is \$25.

Further information, including the dates of the courses, and applications may be obtained from the Postgraduate Division of the College of Dentistry, Ohio State University, Columbus 10, Ohio.

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A married man returned home one night at a late hour and, finding difficulty with his equilibrium, made considerable noise in the hallway. Suddenly, there was a sound of crashing glass which awakened his wife.

"John," she called, "what's the matter?"

From downstairs came a low mumble, "I'll teach those goldfish to snap at me."

Student: "May I kiss your hand?"

Coed: "Whatsa matter, is my mouth dirty?"

★

Jones was sitting with his wife behind a palm on a hotel veranda late one night when a young man and a girl came and sat down on a bench near them.

Hidden behind the palm, Mrs. Jones whispered to her husband, "Oh, John, he doesn't know we're here and he's going to propose. Whistle to warn him."

"What for?" said Jones, "Nobody whistled to warn me."

★

Cpt.: "Pvt. Jones, it gives me great pleasure to present you with these two stripes."

Pvt. Jones: "Why not give me three, sir, and really enjoy yourself."

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Reporter: "To what do you attribute your success?"

Business Man: "Well, I'm trying to make an honest living, and there is no competition."

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Joe: "Who was that guy kissing you? The fresh guy—I'll teach him a thing or two!"

Curvacious cutie: "Don't think you could, chum!"

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She was a lovely young maiden,
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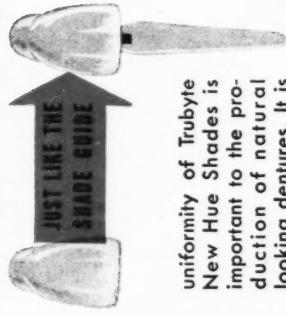
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Sgt.: "I'm a self-made man."

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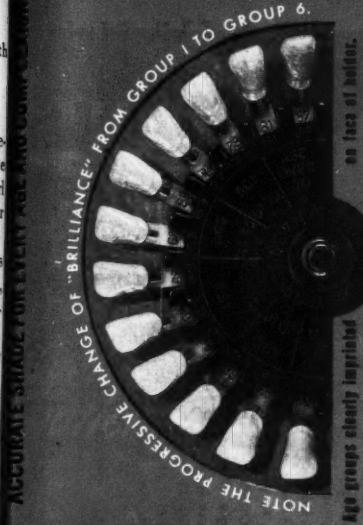
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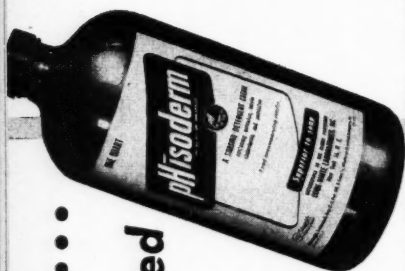
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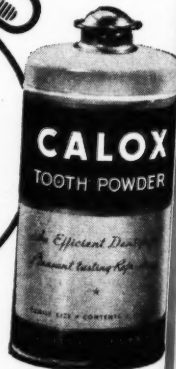
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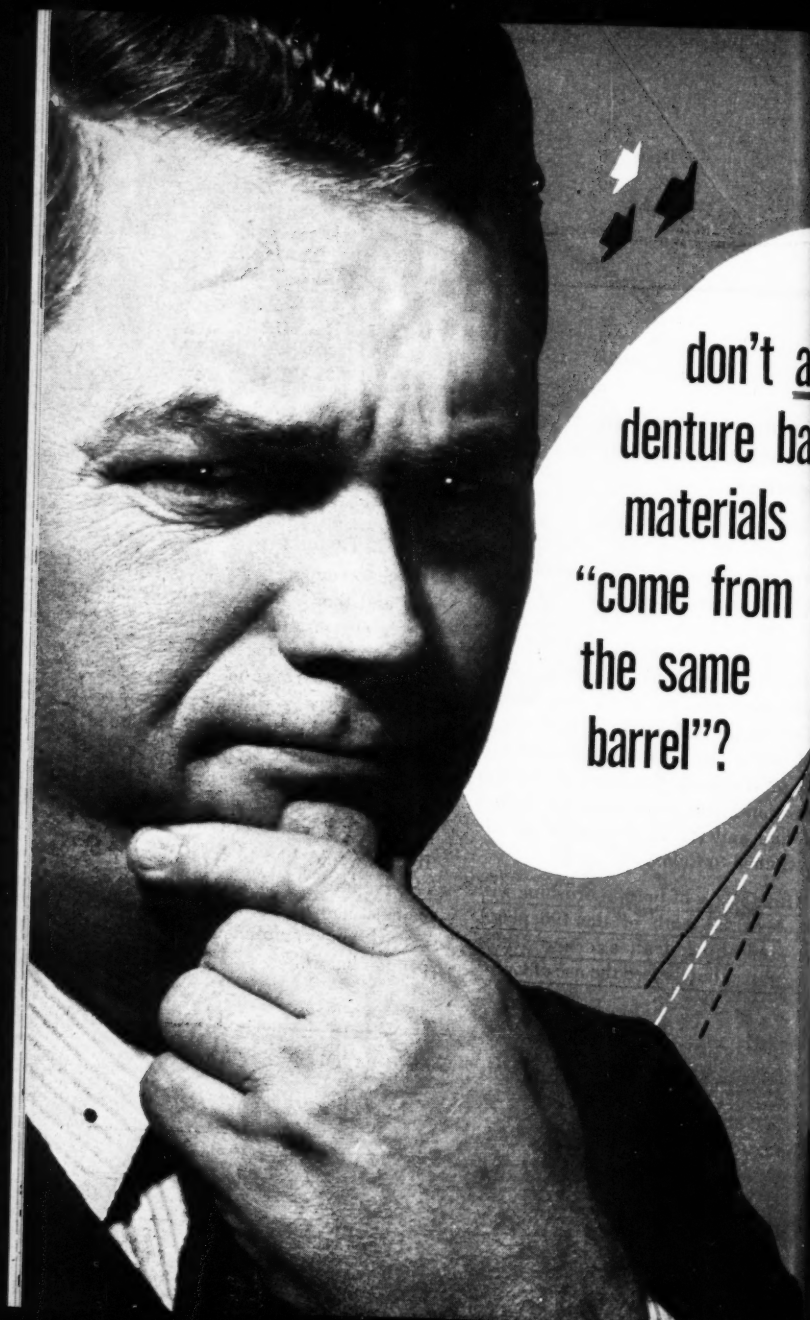
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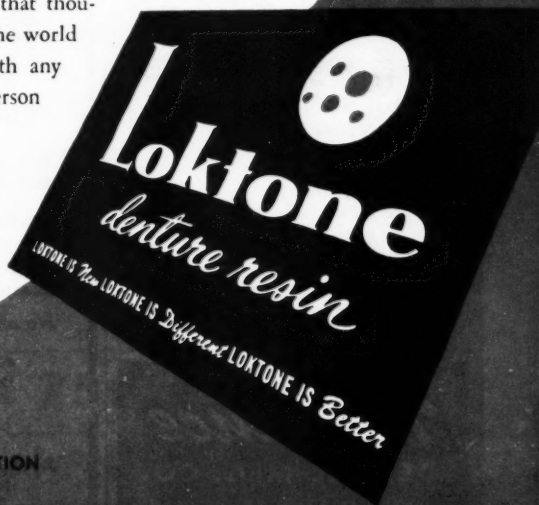


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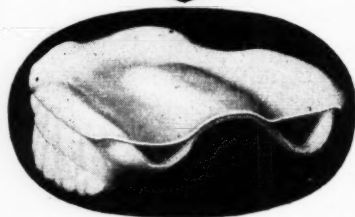
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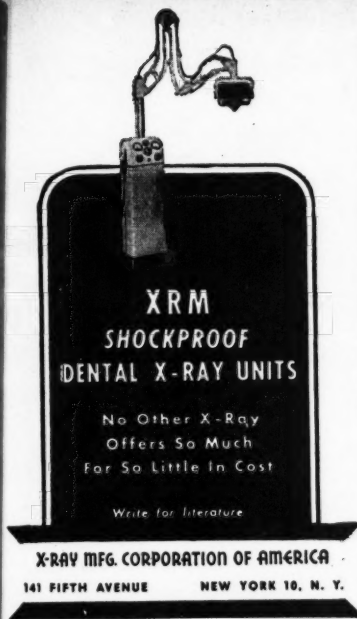
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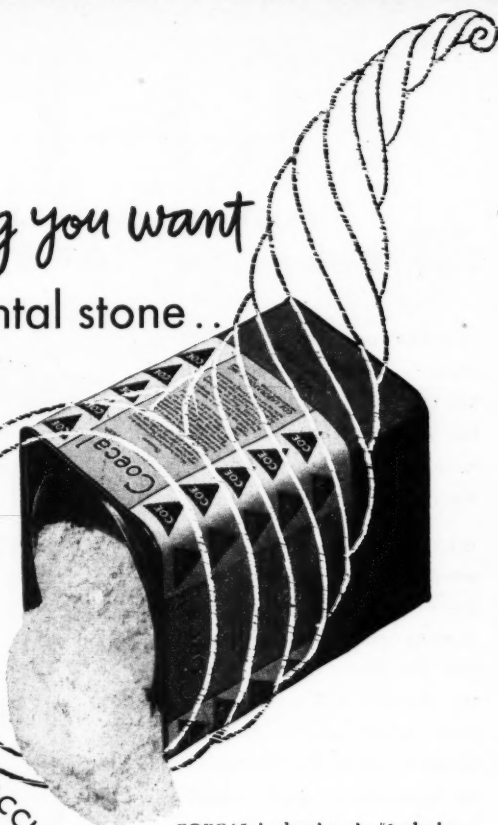
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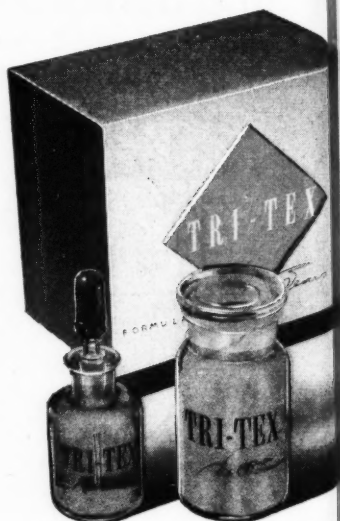
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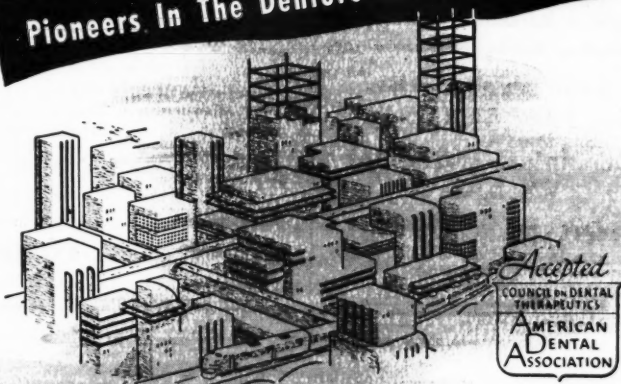
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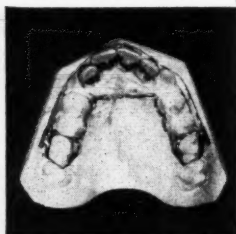
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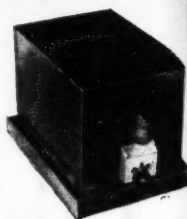
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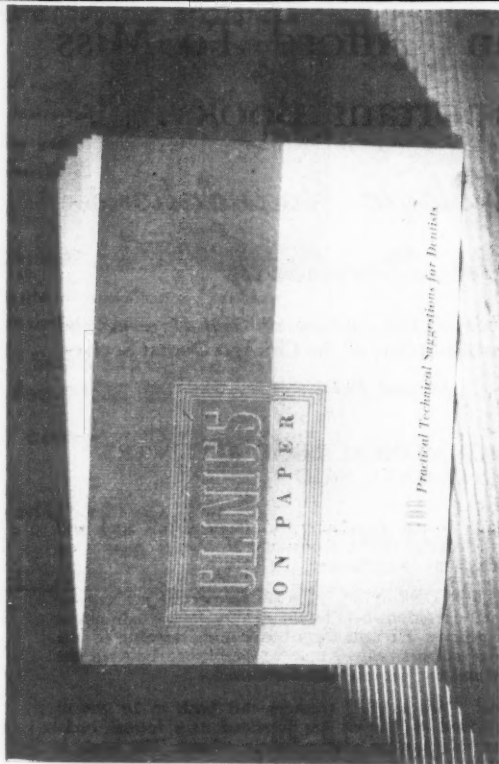
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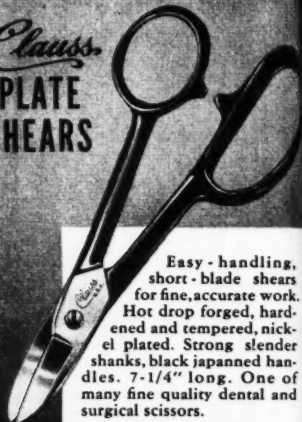
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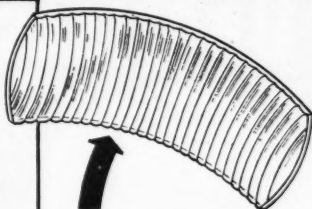
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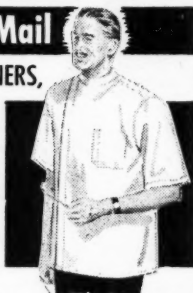
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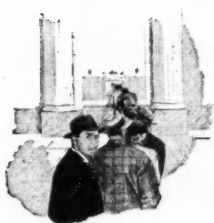
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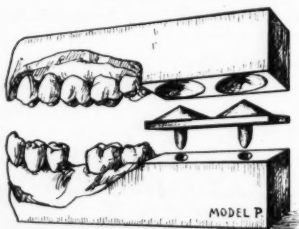
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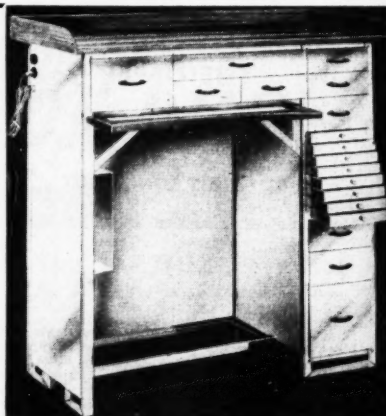
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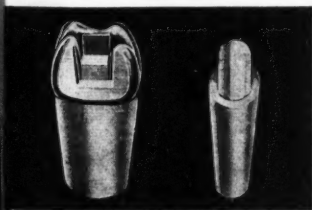
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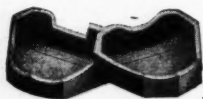
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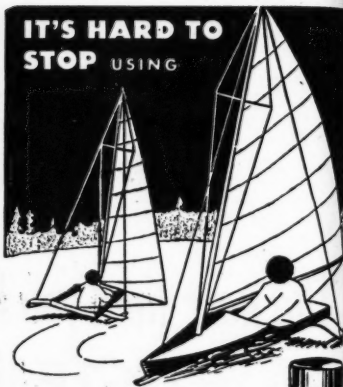
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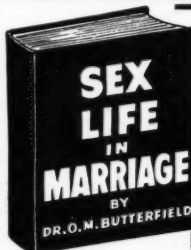


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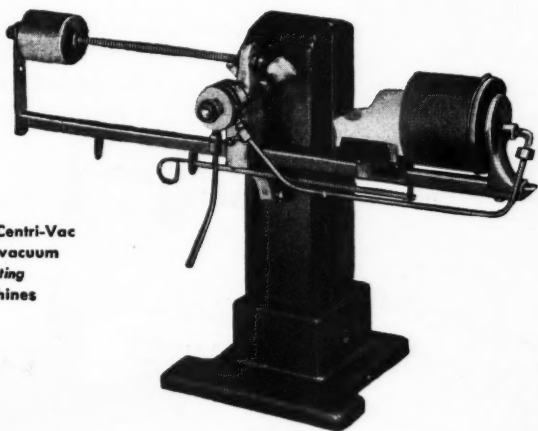
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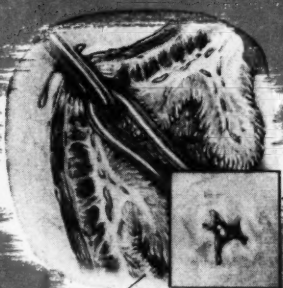
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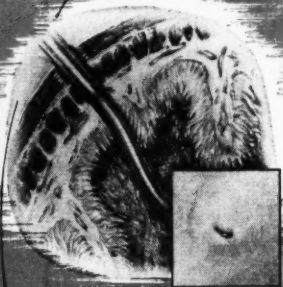
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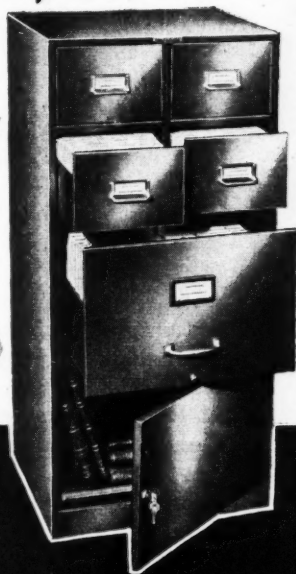
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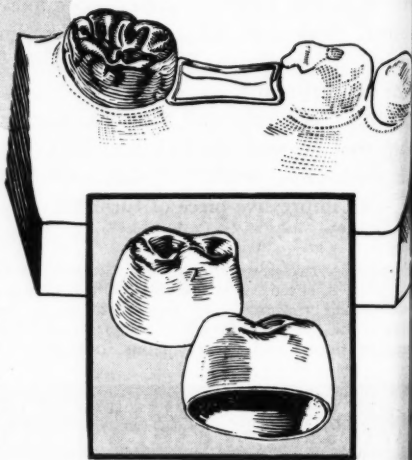
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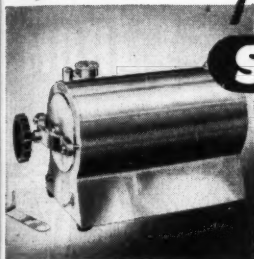
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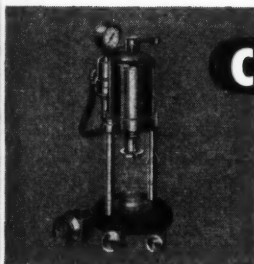
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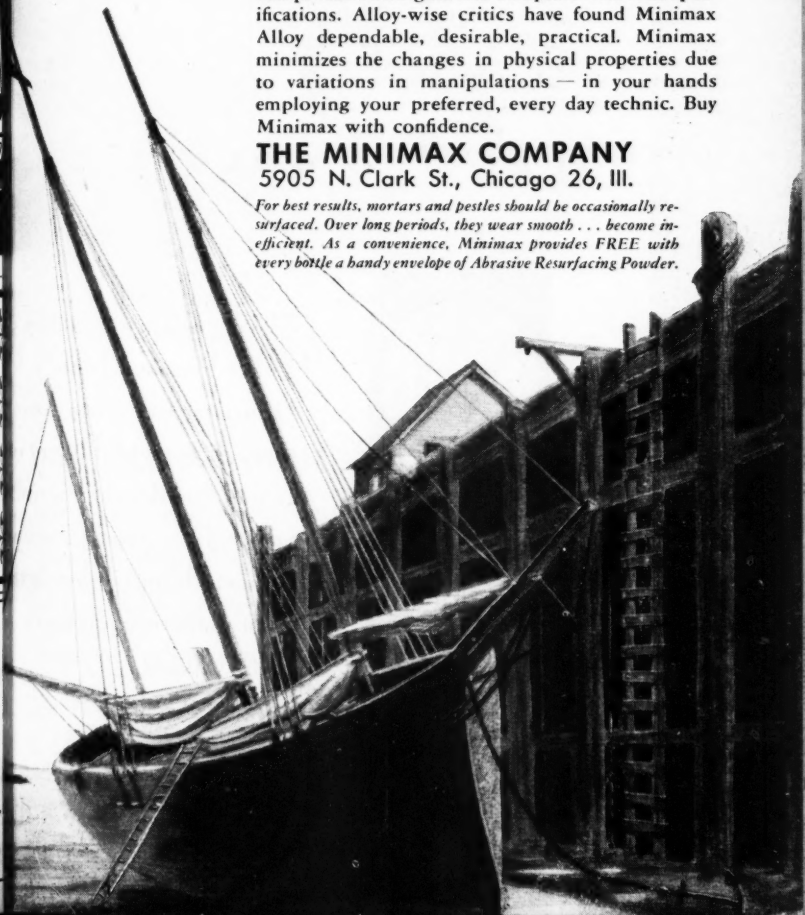
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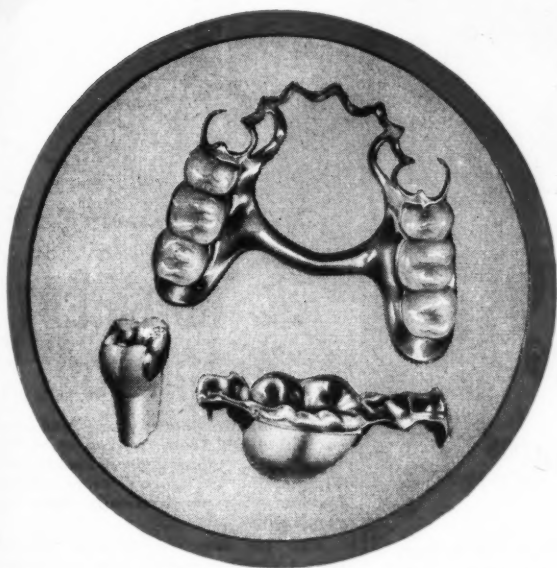
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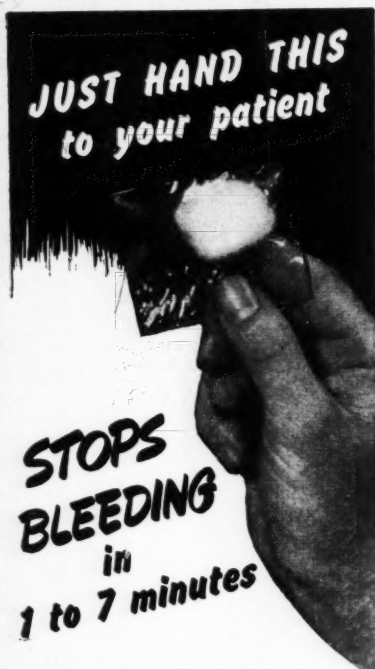
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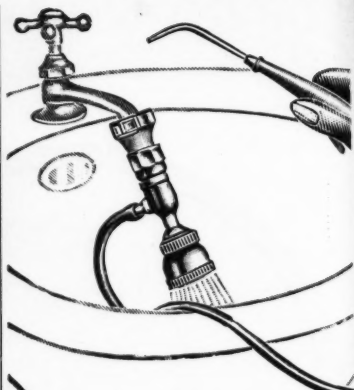
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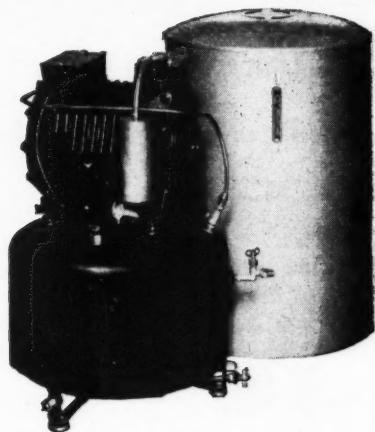
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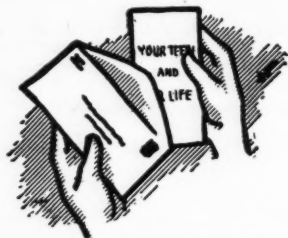
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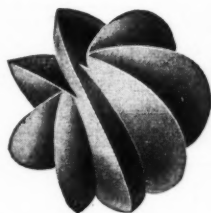
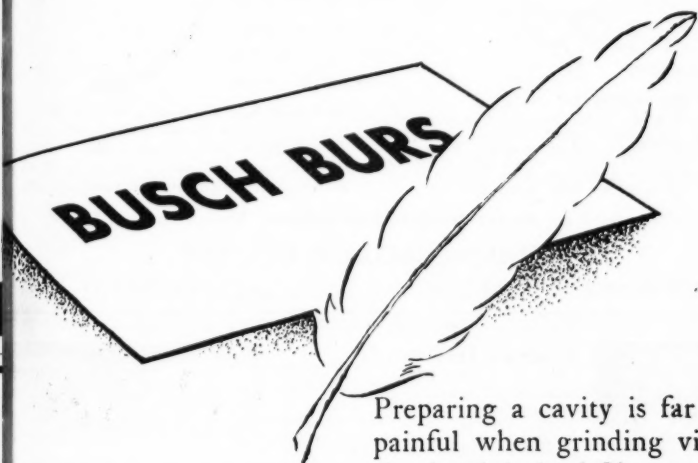
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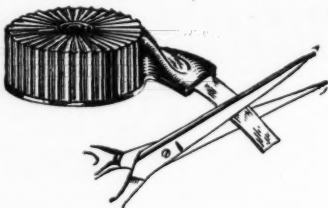
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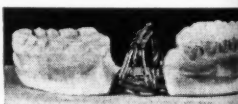
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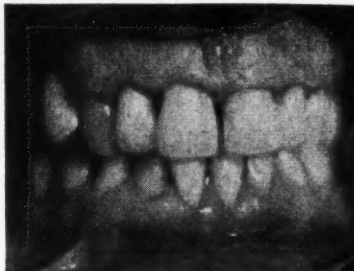
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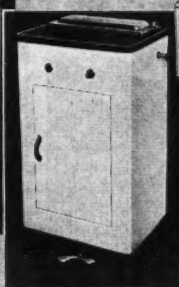
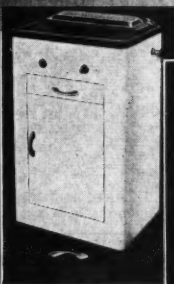
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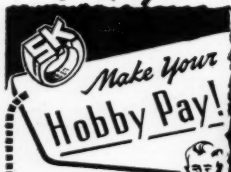
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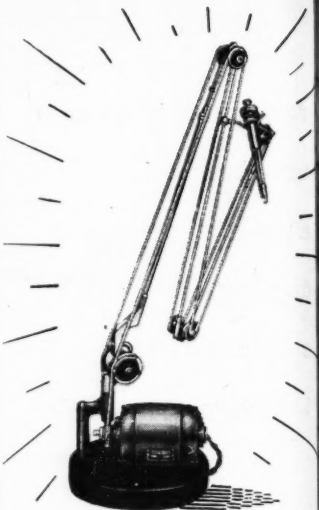
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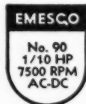


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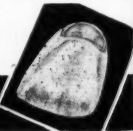
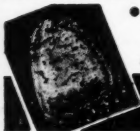
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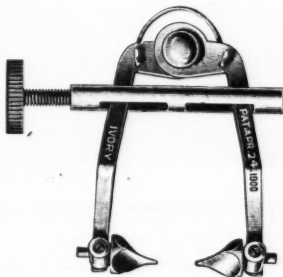


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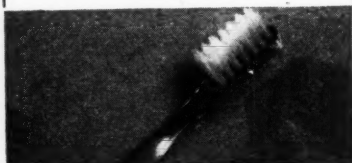
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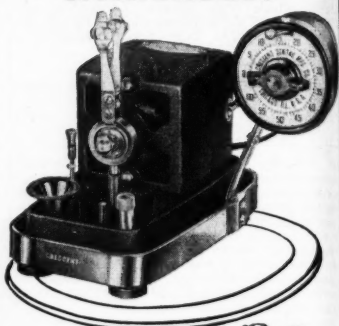
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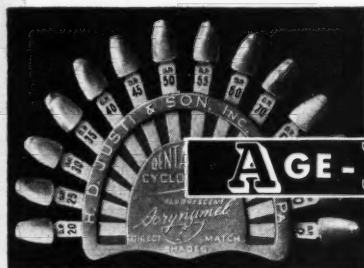
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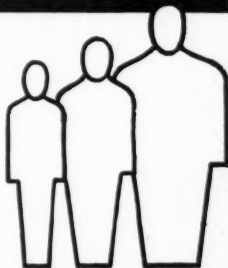
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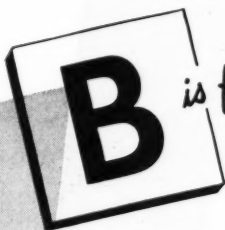
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